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MISSOURI State Board of Nursing Newsletter

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Message from the President

Anne Heyen, DNP, RN, CNE, President

In November, Missouri voters passed Amendment 2 that legalizes medical marijuana in the state. There are two major issues impacting nurses: Nurses who might utilize medical marijuana and nurses caring for the client who is utilizing medical marijuana. Nurses who might utilize medical marijuana need to remember that marijuana in any form remains illegal under federal law. It is a violation of the Missouri Nurse Practice Act to be impaired at work on any controlled substance regardless of whether the substance has been prescribed for them. Employers will have to determine how to manage staff who use and/or possess medical marijuana.

In order to effectively provide care to those who utilize medical marijuana, the National Council of State Boards of Nursing established a marijuana committee that developed Guidelines for Medical Marijuana. These guidelines are included later in this newsletter. All nurses should carefully review the guidelines for nursing care for the patient using medical marijuana. Nurse Practitioners should also review the guidelines for advance practice registered nurses. According to the Missouri amendment, Nurse Practitioners will not be allowed to prescribe medical marijuana, but they will likely have patients who are prescribed medical marijuana and will need to know how to treat those patients. Educators, there is information regarding how to include education about caring for clients taking medical marijuana for pre-licensure and advance practice registered nursing programs. More information will be forthcoming in the next several months as Amendment 2 becomes effective. I encourage all nurses to stay informed on this amendment and its impact on nurses.

Executive Director Report

Registered Nurses Set to Renew in February 2019 – Act Now!

Lori Scheidt, Executive Director

Registered Nurse (RN) renewal postcards with PIN numbers will be mailed in early February 2019. The postcard is mailed to the current address we have on our records. Because you have a legal responsibility to change your name and/or address within 30 days of the change, it is very important that you inform our office, in writing, whenever you have a change in your address. Failure to inform the board of your current residence is cause for license discipline. A change form can be found on the board's website at https://pr.mo.gov/nursing.

RN licenses expire April 30, 2019. It takes up to four business days, after the renewal is submitted, before the license is renewed. We do not issue license cards. Licensure rules require that nurses enroll in **Nursys e-Notify** as a condition of license renewal. A nurse must register "***As a Nurse***" on Nursys e-Notify at https://www.nursys.com/e-notify before continuing with the renewal process. This free service will send the nurse email notifications of changes to his/her license, including when the license is actually renewed, license expiration reminders and changes to any applicable discipline status.

No Grace Period to Renew

There is no grace period to renew. The board's rules were recently changed to require a nurse to renew three business days prior to the expiration date. Failure to do so may result in the license becoming lapsed, which requires the nurse to complete a reinstatement application, submit additional fees and submit to fingerprint background checks.

Check Your Licensure Status and Where You Can Practice

1. Go to nursys.com then click Qnursys QUICKCONFIRM
2. Search by your Name, License Number or NCSBN ID.
3. Click "View Report"
4. On Nursys QuickConfirm Report page, click "Where can the nurse practice as an RN and/or PN?"

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Moments with Marcus

Tribal Culture

Are you a member of a tribe?

To get on the same page, let's define what a tribe is. And, of course, since I'm sorta lazy, this is Alexa's definition, not Daniel Webster's:

Tribe: *Any aggregate of people united by ties of descent from a common ancestor, community of customs and traditions, adherence to the same leaders, etc.*

When thinking of nursing, the "common ancestor" would, of course, be Florence Nightingale. We're not talking about a physical lineage, but a philosophy of caregiving that has been handed down over generations. And a community of customs and traditions? Well, anyone who has worked in nursing should be able to recognize that not all nursing teams are the same. Whether it's a unit in a hospital, a long-term care facility, a professional association, home healthcare company, etc., there are going to be all kinds of different dynamics which arise when groups form. These systems of beliefs and actions add up to what we call "culture."

In my career, I am able to witness, up close and personal, so many different examples of culture in healthcare. One particular visit to a hospital made me so distressed that, when my work was finished, I practically sprinted out the front door. From leadership to volunteers, it seemed like every single person was doing the very least they could. With attitudes like this, how on earth can safety and quality be top of mind? Thankfully, instances like this are rare.

On the opposite end of that cultural spectrum is another group, Tribe RN. Tribe RN isn't a facility or a company, but rather a Facebook group where nurses and student nurses can give and receive support, information and advice. In a time where we see so much on-line trolling and bullying type behavior, this is one of those that bucks that trend.

Marcus Engel

Back in December, I had the awesome opportunity to be interviewed on a Facebook Live by Chelsea, the creator and administrator of Tribe RN. A few weeks before the Live, I joined the group, just to get a feel for their culture and the types of discussions. Whether it was a seasoned nurse seeking advice about a potential medical ethical violation witnessed, or a CNA/student nurse celebrating passing her first semester of nursing school, I have yet to read any type of disparaging comments. Like, at all.

Chelsea states that Tribe RN is a *drama free zone* and asked that, if any member feels attacked, bullied or pressured in any way, let her know - she will handle the complaint.

Putting that out there as a value statement for the group sets the tone. And ya know what? Not only do all the members stick to those guidelines, but they take it a step further. Support. Virtual hugs. "Congrats to you!" type comments… it's a really beautiful thing to witness.

Your nursing job may not always give you unconditional love and support. The culture where you work may be the direct opposite. If so, please find a community of support where the culture of the tribe resonates within your soul to make you a better nurse, colleague and person. Then do all the things you can, to pass that supportive culture along. Even if it's one action at a time.

Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of January 2, 2019

Profession	Number
Licensed Practical Nurse	22,990
Registered Professional Nurse	113,141
Total	**136,131**

SCHEDULE OF BOARD MEETING DATES THROUGH 2019

February 27 - March 1, 2019

May 22-24, 2019

August 7-9, 2019

November 6-8, 2019

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

http://pr.mo.gov

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Nurse Licensure Compact Moving Scenarios

MOVING FROM... **MOVING TO ANOTHER STATE**

Noncompact → Compact:
The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. A multistate license may be issued if residency and eligibility requirements are met. If the nurse holds a single state license issued by the noncompact state, it is not affected.

Compact → Noncompact:
The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. The multistate license of the former NLC state is changed to a single state license upon changing legal residency to a noncompact state. The nurse is responsible for notifying the board of nursing (BON) of the former NLC state of the new address.

Compact → Compact:
When moving (changing primary state of legal residence) to a new NLC state, it is the nurse's responsibility to apply for licensure by endorsement. This should be completed upon moving and the nurse should not delay. There is no grace period. The nurse may not wait until the former license expires to apply in the nurse's new state of legal residency. The nurse may practice on the former home state license only UNTIL the multistate license in the new NLC home state is issued. Proof of residency such as a driver's license may be required. Upon issuance of a new multistate license, the former license is inactivated.

Another Country (International Nurses)
If a nurse on a visa from another country applies for licensure in a compact state, the nurse is responsible for either declaring the country of origin or the compact state as their primary state of residency. If the foreign country is declared the primary state of residency, the nurse may be eligible for a single state license issued by the compact state.

Definition:
Primary State of Residence (PSOR):
The state (also known as the home state) in which a nurse declares a primary residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return or voter registration. PSOR refers to legal residency status and does not pertain to home or property ownership. Only one state can be identified as the primary state of legal residence for NLC purposes.

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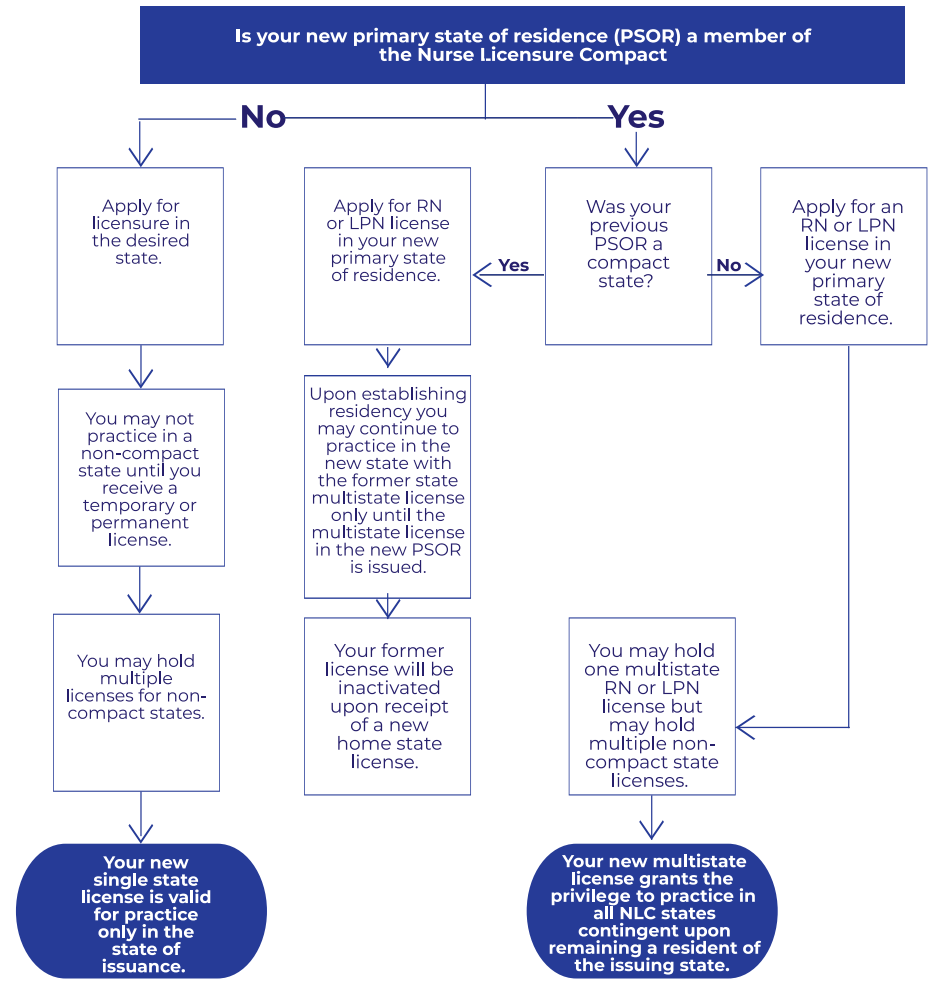
facebook.com/NurseLicensureCompact @NurseCompact

For more information about the NLC, visit **www.ncsbn.org/nlc** or email nursecompact@ncsbn.org.

Navigating the Nurse Licensure Compact: Licensure by Endorsement

When declaring a new primary state of residence (PSOR) or obtaining a license in another state:



New Board Member Appointments

On October 18, 2018, Governor Parson announced four appointments to the Missouri State Board of Nursing. Dr. Anne Heyen, of Ashland, was reappointed to the Board for another term. Dr. Julie Miller, of California; Dr. Robert Walsh, of Ste. Genevieve; and Dr. Sheila Barrett Ray, of Harrisburg, were appointed as new members.

Julie Miller,
DNP, MBA, FNP-BC, CNOR(E), NEA-BC

Dr. Julie Miller is a Nurse Practitioner who enjoys her work in a family practice setting in Jefferson City, Missouri. Dr. Miller is also an adjunct instructor for the University of Missouri Sinclair School of Nursing. She is a three-time graduate of the University of Missouri Sinclair School of Nursing having earned a Bachelor of Science, Master of Science, and Doctorate of Nursing Practice. Dr. Miller also has a Master's in Business Administration from William Woods University. She is a licensed Advanced Practice Registered Nurse-Family Nurse Practitioner and holds certifications as a Nurse-Operating Room (emeritus) and a Nurse Executive Advanced. She is a member of the American Nurses Association, Missouri Nurse Association, Association of Missouri Nurse Practitioners, Sigma Theta Tau International Society of Nursing, and the Sinclair School of Nursing Alumni Association. She is president elect of the Sinclair School of Nursing Alumni Board.

Dr. Miller and her husband, Doug, live in California, Missouri. They have two children. Elle is in her second year of dental school at the University of Oklahoma. Mari is in the sixth grade at California Middle School. The family enjoys Mizzou football as well as Mizzou women's basketball and softball. They are also fans of the St. Louis Cardinals. Dr. Miller is a long time and long distance runner having completed over 30 marathons. In addition to running, she enjoys hot yoga and golf.

Dr. Miller is passionate about patient care and the profession of nursing. She is honored to be serving the citizens of the state of Missouri in this capacity.

Robert Walsh,
MBA, MS, PhD, CRNA

Robert P. Walsh, MBA, MS, PhD, CRNA is Chief Nurse Anesthetist at Ste. Genevieve County Memorial Hospital in Ste. Genevieve, Missouri. He has more than 35 years of clinical and professional experience.

Walsh obtained a PhD from St. Louis University, an MS in Nurse Anesthesia from Webster University, a BA and MBA from Maryville University, and an AAS degree in both Nursing and Respiratory Therapy from St. Louis Community College.

Walsh serves as adjunct faculty at the Goldfarb School of Nursing at Barnes-Jewish College in St. Louis and is an active member of the American Association of Nurse Anesthetists and Missouri Association of Nurse Anesthetists.

Walsh serves as Chair of the Advisory Board - Respiratory Care at St. Louis Community College at Forest Park and has served on the March of Dimes Nurse of the Year Award Selection Committee since 2017. He was awarded the 2016 March of Dimes Nurse of the Year in the area of Advanced Practice.

Walsh also serves as a board member of the Ste. Genevieve County Memorial Hospital Friends Foundation, a charitable organization which funds healthcare-related projects and programs in the Ste. Genevieve County area.

Sheila Ray,
DNP, CRNA, APN

Sheila Ray, DNP, CRNA, APN, is a graduate of the University of South Carolina 1977 Associate Degree in Nursing program, followed by Bachelor of Science in Nursing, Bachelor of Arts in English, and Bachelor of Arts in History. She was recognized on the President and Dean's List for academic excellence. Dr. Ray is also a 1991 Graduate of Richland Memorial Nurse Anesthesia Program, and 2016 Doctorate of Nursing Practice program of the University of Missouri Kansas City. Dr. Ray has nursing experience in private, academic, and government healthcare facilities as a contractor, clinical preceptor, and employee. She is currently practicing as an Advanced Practice Registered Nurse, Certified Registered Nurse Anesthetist, at the University of Missouri, School of Medicine providing anesthesia to a high-risk obstetric population. In 2015, Dr. Ray was honored by colleagues and received the Sigma Theta Tau International Award for Clinical Excellence. She is an active member of the American Association of Nurse Anesthetists and Missouri Association of Nurse Anesthetists. Dr. Ray is a published researcher and innovator that developed an anesthetic safety device to reduce adverse patient outcomes.

During the past forty years, Dr. Ray has witnessed the resilience, integrity, professionalism, and compassion of nurses in healthcare environments that encounter challenges and rewards associated with our profession. The ability to provide exceptional care to a child bravely facing a devastating illness, alleviating the pain of a veteran experiencing posttraumatic stress syndrome, optimizing outcomes for a pregnant heroin addict, or supporting patients and family members during life and death challenges have provided nurses with the opportunity to be powerful advocates for vulnerable populations. She is honored to serve on the Missouri Board of Nursing.

Reflections from Outgoing Board Members

Alyson Weter, RN

Alyson Weter, RN, served on the Board of Nursing as the LPN member from 2014 until 2018. She also served as Secretary of the Board from 2015 until 2017. After her departure from the Board, we followed up with Alyson on her thoughts about her service as a Board member:

What/who/why (any of those) encouraged you to join the Board of Nursing?

I applied to be a part of the Board of Nursing because I felt strongly about the protection of the public. As someone who has come in contact with unsafe healthcare providers both as a patient and as a nurse, it was something I wanted to be a part of.

During the time you've spent on the Board, what would you describe as your most important contributions to public protection?

I believe my most important contribution to public protection would be my ability to see each case as its own entity. I think it is so important to look through every case as if it were the first one you had ever read and base your decision solely on its merits. When we say that we handle everything on a case by case basis, it's true! One of the biggest things I learned as a practicing nurse on the Board is that no one in this world will ever care about your nursing license more than you do. It is up to you to protect your license.

As you complete your time with the Board, what would you say to someone who is considering a Board appointment?

I came onto the Board a little naive as to how much hard work, time, and dedication the Board of Nursing puts into the safety of each and every citizen who seeks healthcare in Missouri. I would tell anyone considering applying for a Board appointment that you have to commit a significant amount of time for the work necessary and you have to truly care about protecting the public. I don't think most people have any idea the time commitment and the dedication it takes to be able to read through each case for every single conference call and every single Board meeting with an unbiased opinion, try to sort out the facts, and make the best decision possible for the public. There is a heavy weight that comes with each decision you make that affects someone else's life, whether it be the nurse or the patient.

Would you recommend Board membership to others?

I would highly recommend Board membership to anyone who feels strongly about keeping patients in Missouri safe. I think that it's humbling to see how your time and effort can make this State a safer place for all those seeking medical care.

We thank Alyson for her service as a Board member and wish her the best of luck in her future endeavors.

Rhonda Shimmens, RN-C, BSN, MBA

Rhonda Shimmens, RN-C, BSN, MBA, served on the Board as an RN member from 2009 until 2018 and as President of the Board from 2014 until 2016. The following are her reflections regarding her service on the Board:

I still recall the day in 2009, working in my office, when I received a call from the Governor's office, asking if I would be interested in applying to be a member of the Missouri State Board of Nursing. At the time, I was working full time and just beginning my Master's Program. I sought advice from a few individuals, and most of the feedback I received encouraged me not to begin both at the same time. Generally, I appreciate the insight. However, in this situation, I decided to go with my heart, and say yes to the application process. After a nomination, appointment by the Governor, and confirmation from the Senate, I began my service as a board member. I also served as President for two years, and was able to participate on the National Council for State Board of Nursing. It was one of the best decisions I have made.

I recently completed my service, and as I reflect on this experience, I am thankful to have been given the opportunity to serve the citizens of Missouri. With the guidance of Lori Scheidt, Executive Director, I have had the privilege of working with an amazing team of board staff. They are committed to the safety and quality of the nursing profession, and truly have the mission of protecting the public in their best interest at all times. In addition, I have shared this journey with many very bright, talented, and passionate members who have devoted their time and energy to serve on the board. I am grateful for the friendships made, and the respect shown as we discussed important topics and issues facing the future of nursing. It has certainly been a learning opportunity for me, and I gained a new perspective on the role of the board, and the challenges they respond to on a day to day basis.

I would like to thank SSM Health, St. Mary's Hospital Jefferson City for supporting this appointment, and allowing me to fulfill the commitment to serve. As my term concludes, I would like to welcome and congratulate the new board members, and wish them continued success in the future.

What Nurse Employers Need to Know

Background

- The NLC allows a nurse (registered nurses [RNs] and licensed practical/vocational nurses [LPN/VNs]) to have one multistate license in the primary state of residence (the home state) and practice in other compact states (remote states), while subject to each state's practice laws and discipline.
- Lawful practice requires that a nurse be licensed or have the privilege to practice in the state where the patient is located at the time care is directed or service is provided. This pertains to in-person or telehealth practice.

- Nurses holding a multistate license are allowed to practice across state lines in other NLC states. However, a multistate license may be converted to single state license when practice is limited to the home state due to a restriction on the license or some level of disciplinary action.
- Advanced practice registered nurses (APRNs) are not included in this compact. APRNs must apply for APRN licensure in each state in which they practice, unless exempted when employed in a federal facility.

Employer Confirmation of a Nurse's Licensure Status

- Employers can confirm a nurse's license and receive a Nursys QuickConfirm report at www.nursys.com at no cost. The report will contain the nurse's name, jurisdiction, license type, license number, compact status, license status, expiration date, discipline against license and discipline against privilege to practice. Employers can also view an individualized authorization to practice map which displays the states where a nurse can legally practice.
- All NLC states provide licensure and discipline data to Nursys® directly from the board of nursing (BON) licensure systems. Nursys is primary source equivalent.
- To confirm APRN and temporary licenses, visit the issuing BON website. A temporary license issued by a compact state is valid in that state only and does not carry multistate status.

Licensure and Privileges

- A nurse licensed in a compact state must meet the uniform licensure requirements in the primary state of residence (home state). When practicing on a privilege in a remote state, the nurse is accountable for complying with the nurse practice act of that state.
- A single state license may be issued to an applicant residing in a noncompact state. A license issued by a noncompact state is valid only in that state.
- The NLC permits a nurse to hold one active multistate license issued by the primary state of residence.
- When a nurse is hired in a remote state for a temporary position or commutes to the remote state from the primary state of residence (usually an adjacent state), employers cannot require the nurse to apply for licensure in the remote state when the nurse has lawfully declared another state as the primary state of residence. This is based on where the nurse pays federal income tax, votes or holds a driver's license. The BON cannot issue a license to a nurse who has declared another compact state as the primary state of residence unless the nurse doesn't meet the multistate license requirements and is limited to a single state license.

Discipline

- It's the responsibility of the nurse to notify the employer of any action taken by the BON against his or her license.
- Under most circumstances, when a license is disciplined, multistate privileges are removed, restricting the nurses' practice to the home state.
- Employers may register their nursing workforce in e-Notify at nursys.com at no cost. Employers will receive e-notifications of disciplinary action taken on any license the nurse holds in the U.S.

Moving to Another State

Noncompact to Compact:

- The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. A multistate license may be issued if residency and eligibility requirements are met. If the nurse holds a single state license issued by the noncompact state, it is not affected.

Compact to Noncompact:

- The nurse is responsible for applying for licensure by endorsement in the new state of residence. The nurse may apply before or after the move. The multistate license of the former NLC state is changed to a single state license upon changing legal residency to a noncompact state. The nurse is responsible for notifying the board of nursing (BON) in the former NLC state of the new address.

Compact to Compact:

- When moving (changing primary state of legal residence) to a new NLC state, it is the nurse's responsibility to apply for licensure by endorsement. This should be completed upon moving and the nurse should not delay. There is not a 90 day grace period. The nurse may practice on the former home state license until the multistate license in the new NLC home state is issued. Proof of residency such as a driver's license may be required. Upon issuance of a new multistate license, the former license is inactivated.

Definitions

- **Compact:** An interstate agreement between two or more states established for the purpose of remedying a particular problem of multistate concern. (*Black's Law Dictionary*)
- **Compact State:** Any state that has adopted the NLC.
- **Home State:** The compact state that serves as the nurse's primary state of residence.
- **Remote State:** A compact state other than the home state where the patient is located at the time nursing care is provided or, in the case of the practice of nursing not involving a patient, a compact state where the recipient of nursing practice is located.
- **Primary State of Residence (PSOR):** The state (also known as the home state) in which a nurse declares a primary residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return or voter registration. PSOR refers to legal residency status and does not pertain to home or property ownership. Only one state can be identified as the primary state of legal residence for NLC purposes.
- **Nursys:** This database (www.nursys.com) provides licensure and disciplinary information of all RNs and LPN/VNs, as contributed by compact states. The public can access Nursys for free to look up a nurse's license and discipline status.
- **Privilege to Practice:** Current, official authority from a remote state permitting the practice of nursing as either an RN or an LPN/VN in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege, such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

For more information about the NLC, visit www.ncsbn.org/nlc or email nursecompact@ncsbn.org.

Frequently Asked Questions

Q1: I live in a noncompact state. How do I get a compact multistate license?

Only nurses who declare a compact state as their primary state of residence may be eligible for multistate license. As a resident of a noncompact state, you may apply for a license by endorsement in a compact state. Your eligibility will be limited to a single state license that is valid in that state only. As a resident of a noncompact state, you can have as many single-state licenses as you wish, but are not eligible for a multistate license.

Q2: Where is the compact application and what is the application fee?

Use the state board of nursing (BON) application for licensure by exam or by endorsement, as found on your BON's website. Licensure fees vary by state. If your legal residence is in a state that joined the compact as of Jan. 19, 2018 (Florida, Georgia, Oklahoma, West Virginia and Wyoming), and you hold a single state license in that state, then you should complete the application for a multistate license on your BON website.

Q3: I live in a compact state and have a license. How do I know if my license is multistate? How do I get a compact license?

If your legal residence is in a state that joined the compact as of Jan. 19, 2018 (Florida, Georgia, Oklahoma, West Virginia and Wyoming), and you hold a single state license in that state, then you should complete the application for a multistate license on your board of nursing website.

If your legal residence is in one of the original compact states and you held a multistate license on July 20, 2017, you may already have a compact license due to being grandfathered. If you're unsure of your licensure status, use the Nursys® QuickConfirm tool at www.nursys.com. This report will indicate "multistate" or "single state" in the status column. When you click on "Where can the nurse practice?" you will see a map (or a list) of all states where you hold the authority to practice.

Q4: I have a compact license. How long can I work in another compact state?

There is no time limit. As long as you maintain legal residency in the state that issued your multistate license and you remain in good standing, you may practice in other compact states.

If you were to take an action (while practicing in another NLC state or otherwise) which would change your legal residency status (see example below), then you have given up legal residency in that home state and you must now apply for license by endorsement in the new state of residence. The new license issued will replace the former license.

For example, a nurse has legal residency in Arizona and practices temporarily in Colorado for six months under the Arizona multistate license. While the nurse is practicing in Colorado, her Arizona driver's license expires. Rather than renewing the Arizona driver's license, the nurse obtains a Colorado driver's license. Because a Colorado driver's license is only issued to a Colorado resident, the nurse has now become a Colorado resident unintentionally. Nurses must be careful not to take actions that would change their state of legal residency, when practicing in another state where they temporarily reside.

Q5: What if I move to another compact state?

When permanently relocating to another compact state, apply for licensure by endorsement and complete the Declaration of Primary State of Residence form within the application, which can be found on your board of nursing's website.

You may start the application process prior to or after the move. You should not delay applying once you have moved. There is no grace period.

- If you are moving from a compact state, you may not wait until your former multistate license expires before applying in your new state of legal residency. You can only practice on your former home state license until the multistate license in the new NLC home state is issued.
- If you are moving from a noncompact state applying to a compact state in advance of the move, you may be issued a single state license or your application may be held until you move and have proof of legal residency at which time you may be issued a multistate license.

Q6: My primary state of residence is a noncompact state; it is also where I am licensed. I am applying for licensure in a compact state. Do I have to give up my current license?

No, you may choose to keep and renew your current noncompact state license.

Q7: I live in a compact state where I am licensed. How do I get a license in a noncompact state?

Apply for licensure by endorsement to the board of nursing in the state where you seek a license. You may be issued a single state license valid only in the state of issuance. Applications can be found on that board of nursing's website. Visit ncsbn.org for board of nursing contact information.

Q8: I am graduating from a nursing program. Can I take the NCLEX® in a different state?

The NCLEX® is a national exam and can be taken in any state convenient to you. It is not a state exam. The results will be directed to the board of nursing where you applied for your authorization to test (ATT) and licensure.

- If you are applying to a compact state for a multistate license, you should apply in the state where you intend to legally reside.
- If you are applying for a license in a noncompact state, you should apply for a license in the state where you intend to practice.

Q9: I live in a noncompact state, but I will be changing my primary state of residence to a compact state in a few months for a job. Can I apply for a license in that state now so I can work immediately after moving?

Yes. You may start the application process prior to the move. A new compact license will not be issued until you provide a Declaration of Primary State of Residence (PSOR) form and any proof of residence that may be required by the board of nursing (BON). Some states offer a temporary license; this may enable you to practice before your permanent license is issued. Check with your BON to see if they offer one.

Q10: I live in a noncompact state, but own property in a compact state. Can I get a compact license?

In order to be eligible for a compact license, your declared primary state of residence must be a compact state. Primary state of residence does not pertain to owning property but rather it refers to your legal residency status. Proof of residence includes obtaining a driver's license, voting/registering to vote or filing federal taxes with an address in that state. These legal documents should be issued by the same state.

Q11: I have a compact license and have accepted a temporary assignment in another compact state. My employer is telling me that I need to get that state's license. Is this true?

When hired in a remote state for a temporary position or commuting to a remote state from the primary state of residence (PSOR) (usually an adjacent state), employers should not require you to apply for licensure in the remote state when you have lawfully declared another state as your PSOR. PSOR is based on where you pay federal income tax, vote and/or hold a driver's license. The remote state board of nursing cannot issue a license to a nurse who has declared another compact state as the PSOR, since the multistate license from the home state applies to both states. You have the privilege to practice in any remote compact state with your multistate license issued by your home state.

Q12: How does the compact work for military or military spouses?

See military fact sheet on our Toolkit webpage at www.ncsbn.org/6183.htm for additional information.

Q13: How does the NLC pertain to advanced practice registered nurses (APRNs)?

The NLC pertains to registered nurses and licensed practical/ vocational nurses licenses only. An APRN must hold an individual state license in each state of APRN practice. Visit ncsbn.org for BON contact information. Visit aprncompact.com for information on that compact.

Q14: Which nurses are grandfathered into the enhanced Nurse Licensure Compact (eNLC) and what does that mean?

Nurses in eNLC states that were members of the original NLC may be grandfathered into the eNLC. Nurses who held a multistate license on the eNLC effective date of July 20, 2017, in original NLC states, may be grandfathered. You can check if you hold a multistate license and the states in which you have the "authority to practice" by following the steps below.

a. Go to nursys.com and click on nursys quick confirm
b. Search by your name, license number or NCSBN ID
c. Click "View Report."
d. On the report page, click "Where can the nurse practice as an RN and/or PN?"

If you do not have a multistate license and you need to change your single state license to a multistate, contact the board of nursing. They may require proof of residence such as a driver's license prior to issuing you a multistate license.

Q15: Why would a nurse need a multistate license?

Nurses are required to be licensed in the state where the recipient of nursing practice is located at the time service is provided. A multistate license allows the nurse to practice in the home state and all compact states with one license issued by the home state. This eliminates the burdensome, costly, and time consuming process of obtaining single state licenses in each state of practice.

Q16: What is the difference between a compact license and a multistate license?

There is no difference between a compact license and a multistate license. This terminology is used interchangeably to reference the Nurse Licensure Compact (NLC) license that allows a nurse to have one license, with the ability to practice in all NLC compact states.

Q17: What do I need to do before I move to another state?

See moving scenarios fact sheet on our Toolkit webpage at www.ncsbn.org/nlc-toolkit.htm.

Q18: What does Primary State of Residence (PSOR) mean?

For compact purposes, PSOR is not related to property ownership in a given state. It is about your legal residency status. Everyone has legal documents such as a driver's license, voter's card, federal income tax return, military form no. 2058, or W2 form from the PSOR. If a nurse's PSOR is a compact state, that nurse may be eligible for a multistate (compact) license. If a nurse cannot declare a compact state as his/her PSOR, that nurse is not eligible for a compact license. They may apply for a single state license in any state where they wish to practice.

The Marijuana Guidelines and Nursing

by Maureen Cahill, MSN, RN, APN-CNS, Senior Policy Advisor, Nursing Regulation, NCSBN

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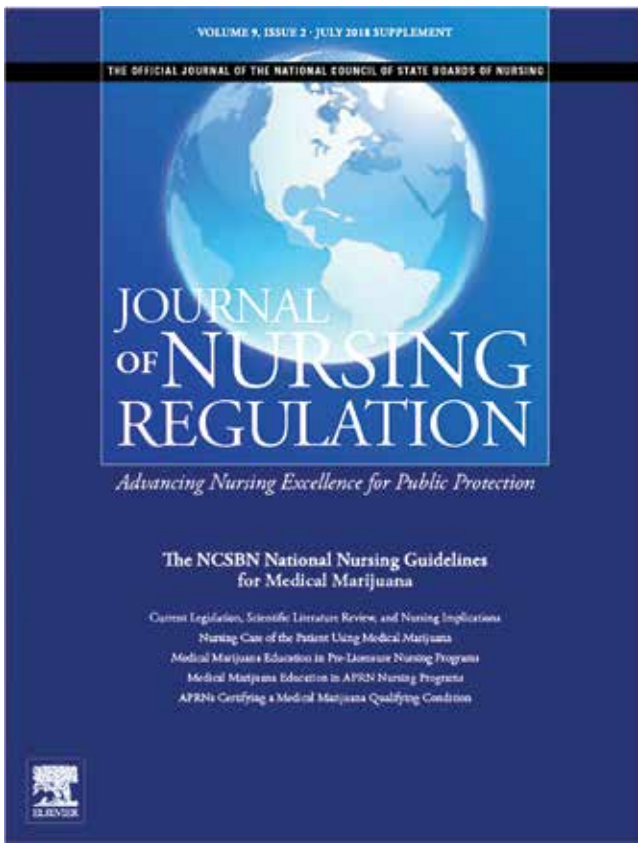
People have used marijuana (or cannabis) across the globe for more than 5,000 years. The plant grows readily in many climates and can be ingested or smoked, making it easy to use. In 1850, the U.S. Pharmacopeia added cannabis to its formulary. By 1937, however, its use was regulated and largely prohibited. Over the ensuing years, federal regulation has waxed and waned, yet recently, states have taken their own actions (U.S. Drug Enforcement Administration, 2001). Federal restrictions on marijuana have limited research to its potential medical use. Because of that, synthetic forms have been studied for the prevention or treatment of nausea and vomiting from chemotherapy (Badowski, 2017). Many nurses have experience with those agents, but other use in medical conditions has occurred largely through experimentation and anecdotal evidence (Kinsey, Ramesh, 2016). By and large, very little has been published that serves as a guide to caring for patients that use cannabis.



The odd history of regulated and unregulated use results in a patient group with some unique characteristics. They often have come to cannabis for a treatment as a last resort, and feel stigmatized by the unorthodoxy of its use. Despite this, they are drawn to try something

new that might alleviate symptoms of their conditions (Crowell, 2016). Marijuana has some clear adverse effects in children and adolescents, and therefore, use is primarily in the adult population. However, Cannabidiol (CBD), a cannabinoid constituent, can be used in an oil form that is widely used to treat intractable seizures in children for which the benefits of seizure reduction are felt to outweigh the risks of adverse effects of minute amounts, if any, of the psychoactive component (Burns, 2018).

Additionally, new indications have moved use into the elderly population (National Council for Aging Care, 2017). A recent breakthrough in this field includes the development of cannabis-derived substances that have been specifically formulated to reduce their psychoactive properties (i.e. THC) (Americans for Safe Access, 2018).

Despite the federal prohibition of marijuana and the continued obstruction of federal funding for research, evidence does exist for particular conditions. The accumulation of evidence was assembled in a 2017 National Academies paper, "The Health Effects of Cannabis and Cannabinoids," (National Academies of Sciences, Engineering, and Medicine, 2017), and in "NCSBN National Nursing Guidelines for Medical Marijuana," the July 2018 supplement to the Journal of Nursing Regulation (NCSBN, 2018).

The NCSBN Board of Directors recognized that nurses were unsure of their responsibilities in the care of these patients, particularly in states that have adopted medical marijuana programs. An expert committee was convened that assembled current evidence as well as guidance for the care of patients on medical marijuana. Additional guidance is provided for those advanced practice registered nurses (APRNs) who might certify that a patient meets a qualifying condition (i.e. those diseases or disorders that are specifically named in the state's medical marijuana statute) and suggests expanded analysis of this treatment modality in nursing programs. The guidelines include recommendations for curriculum content to be added in registered nurse (RN) prelicensure or APRN nursing education curricula.

The principles of caring for the patient taking medical marijuana are essentially similar to other treatment modalities. The nurse must be familiar with both the evidence and the lack of it. The nurse must also show compassion and follow the nursing process. A particular challenge for nurses is that marijuana preparations come in many dosing forms (i.e., inhaled, topical, and oral) (Minnesota Department of Health, 2018). In most cases, there is not a specific weight-based dose provided, and the patient must titrate dose to effect. State and federal regulations do not allow nurses to administer the agent except in the permitted category of "caregiver," with specific requirements met.

Additionally, marijuana is not prescribed, but rather dispensed, if state-listed condition requirements are met. Health care providers certify to the qualifying condition, but still have a duty to monitor the condition and the patient's response to this therapeutic option. Indeed, medical marijuana is not a trial of last resort, and providers should always be considering alternative or additional therapeutic options if desired effects are not reached.

> The principles of caring for the patient taking medical marijuana are essentially similar to other treatment modalities. The nurse must be familiar with both the evidence and the lack of it.

The NCSBN Marijuana Committee also recognized that it has been difficult for schools to adequately embed information about the care of the patient using medical marijuana because such use was varied, and still federally restricted. With a growing number of states allowing its use for qualifying conditions, nurses will increasingly be caring for such patients. To encourage curricular expansion of this topic, guidelines stress knowledge of the endocannabinoid system, both potential adverse effects and synergistic effects of the agents, and basic principles of monitoring for effect and continued care planning for this patient group. Nurses at all levels will benefit by enhanced program content on medical marijuana, and with more complete knowledge of the evidence and issues in care that exist today.

> … it has been difficult for schools to adequately embed information about the care of the patient using medical marijuana because such use was varied, and still federally restricted.

Please visit NCSBN's Guidelines for Medical Marijuana for more information, including a link to the National Nursing Guidelines for Marijuana, now available free of charge.

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Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

The Board of Nursing is requesting contact from the following individuals:

Kelly Kean – PN 2007028791
Kara Jean Israel – RN 2014021870
Christine Michelle Johnson – PN 2005009292
Maggie Elizabeth Minnigerode – RN 2013044829
Katherine Montgomery – PN 2005021096

If anyone has knowledge of their whereabouts, please contact Kristi at 573-751-0082 or send an email to nursing@pr.mo.gov

CENSURE

Whalen, Leiza Dawn
Blue Springs, MO
Registered Nurse 2002013531
On December 23, 2013, Licensee arrived to work late. Licensee was the operating room nurse assisting doctor KW with a procedure. While Licensee was supposed to be assisting with Doctor KW's surgical procedure, Licensee left the operating room while her patient was still in the operating room, and was observed in the locker room applying makeup. Licensee did not request for another nurse to provide coverage in the operating room while she was out of the operating room. Licensee was unable to perform the duties and functions of a registered professional nurse and abandoned her patient during a surgical procedure.

Knuckles, Elizabeth A
Dittmer, MO
Registered Nurse 151065
Licensee was observed by co-workers displaying erratic behavior, which included hand tremors, refusing to make eye contact, difficulty communicating, and the constant exaggerated scratching of her legs. Licensee stayed three (3) hours after this shift to complete documentation; however, it was discovered later that three (3) of Licensee's four (4) patients still had incomplete documentation. On April 19, 2015, Licensee did not show up for her scheduled shift until four (4) hours after the shift began. Licensee was asked to complete the documentation on the patients from the previous shift; however, Licensee failed to complete the documentation. On April 20, 2015, Licensee was observed displaying erratic behavior again. Licensee stayed four (4) hours after this shift to complete documentation; however, documentation was still incomplete on five (5) patients. Licensee failed to document the vital signs for three (3) patients and she failed to document the administration of medication and a neurological examination for two (2) patients. According to the Pyxis report, Licensee withdrew 20 mg of oxycodone at 2019 and documented administering 5 mg at 0154, but 15 mg of oxycodone was not documented as administered or wasted. Additionally, according to the Pyxis report, Licensee withdrew two (2) tablets of Percocet at 2205, but failed to document the administration or waste of the medication.

Martin, Mary L
Neosho, MO
Registered Nurse 094839
Licensee practiced nursing in Missouri without a license from May 1, 2017 to June 15, 2018.

Taylor, Katherine Suzanne
Washburn, MO
Registered Nurse 2016013095
On September 2, 2017, Licensee discharged a newborn patient from the hospital at approximately 21:00. Licensee documented that she had completed a required congenital heart disease screening on the patient at 19:00 on September 2, 2017. When questioned later by hospital administrators, Licensee stated she had not actually completed the screening. Licensee had the patient return to the hospital on September 3, 2017, and completed the screening on September 3, 2017, at 11:50. Licensee failed to return to work at the hospital for her scheduled shifts on September 8, 2017 and September 9, 2017, and was subsequently terminated.

Rowland, Nicholas Glen
Sedalia, MO
Licensed Practical Nurse 2008026192
Licensee practiced nursing in Missouri without a license from June 1, 2016 to May 9, 2018.

Griffin, Brenda L
Wathena, KS
Registered Nurse 112192
Licensee practiced nursing in Missouri without a license from May 1, 2017 to July 26, 2018.

Carter, Ruby Denise
Saint Louis, MO
Registered Nurse 2010018730
During early August 2014, Licensee's co-workers began to notice Licensee's odd behavior and questionable documentation. On the weekend of August 9-10, 2014, Licensee admitted to employer's senior marketing manager to forcefully administering Vicodin to patient D.K., who was fully alert and oriented. Patient D.K. expressed that he did not want the medication. Licensee retorted that she had done so as she believed it "was for DK's own good." On August 9, 2014, Licensee admitted knowing patient D.K. had fallen in his room, yet she did nothing until another staff member pointed out to her that he had fallen and that staff member helped him up. Licensee admitted to the Board's investigator that she knew that patient D.K. "consistently fell," and stated she knew he "was on top of a floor mat, not the floor." On August 13, 2014, Licensee did not document on patient CB, who was assigned to her, for the entirety of her shift from 7:00 am to 7:30 pm. Therefore, patient CB did not have documentation for the entirety of that shift, an assessment, her vital signs, any medication administration, or her discharge summary or notes before finally being discharged that evening at 7:30 pm.

Lamb, Michelle Elizabeth
Columbia, MO
Registered Nurse 2014004469
Licensee practiced nursing in Missouri without a license from May 1, 2017 to July 27, 2018.

McMeans, Sherri D
Lees Summit, MO
Licensed Practical Nurse 2002005597
On September 1, 2017, while working the overnight shift, Licensee was taking care of J.P. During the evening of September 1, 2017, Licensee went to the neighbor's house of the patient and consumed wine. Licensee then returned to patient J.P.'s house to continue her shift. Licensee was observed to be unsteady on her feet, with bloodshot eyes and slurred speech. Previously, Licensee had been instructed on the proper way to administer J.P.'s liquid medication as to prevent choking. On September 1, 2017, Licensee did not follow the instructions and administered the liquid medication with the patient on her back, causing the patient to cough and choke.

Fahey, Elizabeth Anne
Grafton, WI
Registered Nurse 2015040187
While Licensee was giving report on July 7, 2016, she showed the oncoming nurse a picture of a patient's wound

Censure continued on page 10

Disciplinary Actions**

Censure continued from page 9

she had taken on her personal cell phone. Licensee had sent the picture of the patient's wound with a caption to a nurse that had been previously working as well as showed several coworkers. When questioned, Licensee admitted to sending the picture on Snapchat. Licensee's actions, through taking the picture and sharing with others, violated the patient's rights, privacy and dignity.

Nigh, Tammy Michelle
Saint Louis, MO
Registered Nurse 2008003335
On or about October 6, 2017, Licensee had called in an unauthorized prescription for Tranxene for a close family member, a parent. Licensee's family member is not a patient in the care of the Palliative Care program or a patient of Licensee's collaborating physician. On October 10, 2017, Licensee notified her collaborating physician that she called in a prescription for Licensee's mother for Tranxene. As outlined in the Licensee's collaborative agreement, "ANP shall not prescribe any drugs, medication, device or therapies that Physician is not qualified or authorized to prescribe."

Jacobs, Terrilyn B
Chesterfield, MO
Registered Nurse 116412
Licensee practiced nursing in Missouri without a license from May 1, 2017 to August 1, 2018.

PROBATION

Litteken, Michelle Kara
Ballwin, MO
Registered Nurse 2004018546
Respondent received warnings for excessive absenteeism from a hospital. Respondent was asked to submit to a for-cause drug screen due, in part, to incorrect documentation for wasting narcotics. Respondent's drug screen tested positive for marijuana.
Probation 09/26/2018 to 09/26/2023

Reuter, Faye Artis
Viburnum, MO
Licensed Practical Nurse 2003018575
A resident's family expressed to nursing home administrators concerns regarding a bill from the pharmacy for a large amount of hydrocodone, when the family had been informed the medication was being discontinued. An investigation by nursing home administrators revealed that Licensee ordered hydrocodone for the resident but failed to add it to the medication cart or narcotic count. The investigation showed that Licensee had ordered hydrocodone and Percocet for residents in this manner seven (7) times over a four-month period, without putting the medications in the narcotic count. When questioned, Licensee failed to offer an explanation for the missing narcotics.
Probation 11/09/2018 to 11/09/2021

Huffman, Janet M
Springfield, MO
Registered Nurse 123513
Respondent admitted that she took morphine and hydromorphone from the hospital and used them for her personal consumption. Respondent did not have a prescription for, or a lawful reason to possess, morphine or hydromorphone.
Probation 10/25/2018 to 10/25/2023

Drury, Sasha
Ashland, MO
Registered Nurse 2006010191
From July 28, 2015, until the filing of the Complaint, Respondent failed to check in with NTS on one (1) day, August 2, 2016. Further, on July 10, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on two (2) separate occasions, August 11, 2016 and September 1, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On August 11, 2016, the low creatinine reading was 13.8. Respondent's creatinine reading was 16.4 for the September 1, 2017, sample. A creatinine reading below 20.0 is suspicious for a diluted sample. As part of the terms of her disciplinary period, Respondent was required to completely abstain from the use or consumption of alcohol in any form regardless of whether treatment was recommended. On May 11, 2018, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate, metabolites of alcohol. Respondent admitted that she had consumed a glass of wine the night before the test.
Probation 09/26/2018 to 09/26/2021

Wagner, Elisabeth Ann
Marshfield, MO
Registered Nurse 2014022820
On May 26, 2018, Respondent submitted to a random drug screen, which tested positive for ETG/ETS, which are metabolites of alcohol. At the hearing, Respondent admitted to having consumed alcohol approximately once per week after having her license placed on probation, until May 26, 2018. She denied consuming alcohol after that time. Respondent was aware that consuming alcohol violated the probationary terms placed on her license and chose to consume alcohol weekly despite that prohibition.
Probation 10/25/2018 to 10/25/2023

Bagby, Alan D
Saint Joseph, MO
Registered Nurse 146218
On June 20, 2014, the Kansas State Board of Nursing issued a Summary Order revoking the Kansas nursing license of Licensee for engaging in unprofessional conduct by soliciting prostitution using company email while working as a nurse and failing to respond to that Boards investigator. On December 29, 2015, Licensee and the Nebraska Board of Nursing entered into a Stipulation and Agreed Settlement, which became effective on January 19, 2016. In the Agreed Settlement, Licensees Nebraska nursing license was placed on probation for a period of three years due to Licensees revocation by the Kansas Board. On or about March 17, 2017, Licensee placed his Nebraska nursing license on an inactive status. Licensees Nebraska nursing license was reinstated on or about September 21, 2017, with the period of probation set to continue until August 5, 2019.
Probation 09/24/2018 to 08/05/2019

Persell, Kathleen M
Lees Summit, MO
Registered Nurse 146564
An investigation into Licensee's documentation revealed that Licensee documented visits to clients who denied receiving visits, and also documented visits on a client who was deceased. The investigation further revealed that Licensee was not visiting her clients once per week, as required.
Probation 09/25/2018 to 09/25/2020

Perez, Erin Shay
Blue Springs, MO
Registered Nurse 2013028483
Respondent admitted to ingesting waste from the Fentanyl administered to patients. Respondent submitted to the urine drug screen which was positive for Fentanyl and its metabolites. Respondent did not have a prescription for Fentanyl. On September 8, 2014, Respondent submitted to a pre-employment drug screen. Respondent tested positive for Propoxyphene. On June 26, 2015, Respondent stole Oxycodone by taking it from a patient's purse. Respondent did not have a prescription for oxycodone. On August 25, 2015, Respondent was arrested for Driving While Intoxicated in Jackson County, Missouri. Respondent pled guilty to the Class B misdemeanor of Driving While Intoxicated on December 12, 2016. She was placed on

Disciplinary Actions**

probation that included 10-days shock incarceration. Prior to becoming a nurse, Respondent was convicted of Driving While Intoxicated on two other occasions: January 5, 2012 and February 24, 2005.
Probation 10/22/2018 to 10/22/2023

Ives, Nicole Marie
De Soto, MO
Licensed Practical Nurse 2010037179
On or about October 4, 2017, a resident was transferred to another hall within the nursing home with a medication card containing 42 Percocet tablets. The resident's medication card was handed off to Licensee. On or about October 5, 2017, it was noted that a handwritten narcotic count sheet completed by Licensee for the resident only contained 11 Percocet tablets. When questioned, Licensee stated she lost the preprinted pharmacy narcotic count sheet so she created a handwritten count sheet. An investigation by administrators revealed multiple preprinted pharmacy narcotic count sheets torn up in a paper recycle bin. One of the torn up count sheets was for Norco for resident I.N., and was last used on September 22, 2017, with 27 tablets remaining. On September 23, 2017, Licensee started a new medication card and narcotic count sheet for Norco for resident I.N., leaving 27 Norco tablets unaccounted for. A second torn up count sheet was for Norco for resident D.T., and was last used on September 22, 2017, with 42 tablets remaining. On September 23, 2017, Licensee started a new medication card and narcotic count sheet for Norco for resident D.T., leaving 42 Norco tablets unaccounted for. Additionally, the investigation revealed a torn up shift-to-shift narcotic package count sheet that was last used on September 22, 2017, and noted 19 packages. Licensee created a new shift-to-shift narcotic package count sheet on September 23, 2017, which only noted 17 packets. When questioned about the discrepancies, Licensee denied any knowledge of the missing medication.
Probation 09/07/2018 to 09/07/2020

Odom, Janice Lee
West Plains, MO
Registered Nurse 2009033027
From January 29, 2018, until the filing of the Complaint, Respondent failed to check in with NTS on two days. On April 27, 2018, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate, metabolites of alcohol. Respondent admitted to Dr. Greg Elam that she had been drinking the night prior to the test.
Probation 09/25/2018 to 09/25/2023

Griffon, Sandra K
Farmington, MO
Licensed Practical Nurse 026792
On July 26, 2017, a Pharmacist called a patient to verify her personal information in regards to a prescription for Clindamycin 2% and a Z-Pak. The patient stated to the pharmacist that her niece, Licensee, had told her she would get her the prescription. The pharmacist then called MMC to verify the prescription, which had been called in for the patient. The pharmacist verified that the patient was not a patient of J.B., FNP. Licensee had called in a prescription for a Z-Pak and Clindamycin 2% for the patient using the name of her coworker. Licensee called in unauthorized prescriptions for Clindamycin 2% on April 28, 2017, May 28, 2017, June 29, 2017, and July 25, 2017. Licensee did not have authorization to call in the prescriptions or to use the DEA registration number.
Probation 09/04/2018 to 09/04/2019

Cook, Heather Rochelle
Battlefield, MO
Registered Nurse 2009020149
Licensee admitted that in February of 2015 she was still experiencing pain, and she had become addicted to her pain medicine. It was about this time she started diverting from the hospital, continuing off and on until September 2016. License also admitted to having a dealer from whom she purchased Oxycodone until October 2017. On December 19, 2017, Licensee self-reported to the Missouri Board of Nursing her addiction to opiates and diversion of Oxycodone from her previous employer. Licensee admitted to obtaining Percocet/Oxycodone for patients, while also taking Tylenol that was floor stock for the nurse employees, and replacing the Percocet/Oxycodone with the Tylenol. Licensee admitted to scanning the Percocet/Oxycodone tablets and patient identification wrist band, but giving the patient Tylenol instead of the Percocet/Oxycodone as ordered.
Probation 11/29/2018 to 11/29/2023

Walker, Alvin T
Saint Peters, MO
Licensed Practical Nurse 044721
From February 3, 2016, until the filing of the Complaint, Respondent failed to check in with NTS on twenty-eight (28) days. Further, on September 6, 2016, June 1, 2017, June 22, 2017, June 27, 2017, August 3, 2017, January 5, 2018, February 6, 2018, March 28, 2018, and April 19, 2018, Respondent checked in with NTS and was advised that he had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of February 22, 2018. The Board did not receive proof of continued support group attendance by the documentation due date of August 22, 2017.
Probation 10/22/2018 to 02/22/2020

Gaffney, Jana I
Lees Summit, MO
Registered Nurse 2002017908
On or about November 30, 2017, emergency medical personnel found a partially used vial of Fentanyl at the residence of a patient, who is documented as Licensee's mother. Emergency medical personnel reported the Fentanyl issue to the Police Department. When questioned by Hospital administrators, Licensee stated that she had accidentally removed a Fentanyl vial from the Hospital in her work jacket and taken it to her mother's home. A review was done of Licensee's Fentanyl transactions for the three months prior to the incident. The review showed multiple instances of Licensee failing to properly document the waste of Fentanyl.
Probation 10/10/2018 to 10/10/2021

Miller, Jessica Lynn
Saint Louis, MO
Registered Nurse 2018034556
On February 8, 2011 Applicant pled no contest to Operating a Vehicle Impaired (OVI) after testing positive for marijuana and benzodiazepines following an arrest. On April 2, 2014, Applicant was arrested for possession of a controlled substance and destruction of property. The charges were later dismissed. Applicant admitted to possessing heroin, a controlled substance pursuant to õ195.017.2(3)(k) RSMo. Applicant entered treatment at Harris House on October 16, 2014, and was successfully discharged on November 16, 2016. Applicant states that she attends 12-step meetings one to two times per week and has had the same sponsor for three years. Applicant states her sobriety date is October 13, 2014.
Probation 09/19/2018 to 09/19/2019

Sweeny, Fay A
Centerview, MO
Licensed Practical Nurse 054198
On October 21, 2016, officials received a complaint, stating a patient had not received treatment of Nystatin powder. Licensee had documents in the Treatment Administration Record (TAR) that she had administered the treatment, but Licensee failed to record in the nursing notes that she had administered the treatment. Licensee admitted that she had planned to do the Nystatin powder treatment and documented it in the TAR in advance

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Disciplinary Actions**

Probation continued from page 11

of the treatment, but then failed to actually administer the treatment and did not modify the TAR. On or about November 25, 2016, CHRC was notified of patient, that he did not look well. An official examined patient and found him unresponsive and pale. Through investigation, it was found that the patient had been a patient of the Licensee on November 23 and 24, 2016. Licensee failed to document Coumadin medication and to assess patient for bruising and bleeding, as well as not documenting her assessment of patients Jackson-Pratt (JP) drain site for infection. Further Licensee failed to contact patient's physician to notify him in the change in the patient's condition. On November 30, 2016, a patient was involved in a physical altercation with another resident. Licensee failed to document this altercation in the residents nursing notes, to do a physical assessment of the patient, or to notify the resident's physician of these developments. On January 5, 2017, Licensee documented in the TAR that she had applied prescribed antifungal cream with Tulfa dressing on patient. This treatment would not have been possible because there was no antifungal cream in the facility on January 5, 2017.
Probation 09/05/2018 to 09/05/2019

Bone, Nicole Marie
Warrenton, MO
Registered Nurse 2011021496
At all times relevant herein, Licensee was employed as a registered nurse in the emergency department at a hospital. On or about February 13, 2017, Licensee's name was listed on the proactive diversion report run by Hospital pharmacy. An investigation by Hospital administration revealed questionable documentation of controlled substances by Licensee. The investigation revealed that Licensee failed to document administration or waste of Hydromorphone on numerous occasions.
Probation 09/13/2018 to 09/13/2021

Trumbower, Elisabeth Joan
Columbia, MO
Registered Nurse 2011016690
On March 1, 2018, Respondent pled guilty to the offense of Obtaining a Controlled Substance by Misrepresentation, Fraud, Forgery, Deception or Subterfuge.
Probation 09/25/2018 to 09/25/2023

Rollett, Katherine Jo
Miller, MO
Registered Nurse 2001016549
On December 11, 2017, Respondent pled guilty to the class C felony of Domestic Assault - 2nd Degree, in violation of õ565.073, RSMo., in the Circuit Court of Lawrence County, Missouri, in case number 16LW-CR00272-01.
Probation 10/29/2018 to 10/29/2021

Wagner, Michael Thomas
Lawrence, KS
Registered Nurse 2017012690
On April 3, 2018, Respondent and the Kansas State Board of Nursing agreed, in a Consent Agreement, to the revocation of Respondent's Kansas nursing license. The original Petition, filed by the Kansas Board on September 20, 2017, found the following: On November 8, 2016 while employed at Hospital, the licensee's co-worker reported that he smelled of alcohol. Per the hospital's policy the licensee was then tested for the presence of alcohol. Two tests were both positive for alcohol in excess of .04%. Licensee has refused to enter the KNAP program. Respondent consumed approximately one liter of wine every evening for over a year and had consumed that amount the evening prior to taking the breathalyzer tests.
Probation 10/09/2018 to 11/04/2018

Powell, Leigh A
Coffey, MO
Licensed Practical Nurse 041008
Licensee did not appropriately destroy medications and did not appropriately witness another nurses destruction of medications. Licensee admitted to diverting three pills of Norco or Percocet on two separate occasions for her own personal use.
Probation 10/19/2018 to 10/19/2023

Chumbley, Amber Michelle
Sullivan, MO
Licensed Practical Nurse 2009031098
On or about June 19, 2017, co-workers reported Licensee exhibiting erratic behavior including failing to give report, failing to do the narcotic count, speaking incoherently, and dozing off. The narcotic count was performed by the Director of Nursing and the Assistant Director of Nursing, and multiple discrepancies were discovered. It was noted that Licensee signed out narcotic medication for three residents (J.K., M.R., and W.H) who did not report pain. Urine drug screens performed on the three residents came back negative for opioids. Licensee was asked to submit to a for-cause drug screen, which was returned negative. On or about June 23, 2017, Licensee was asked to submit to a second drug screen; however, Licensee refused to submit the sample. Licensee was terminated from the nursing home effective June 19, 2017, due to refusing to submit to a for-cause drug screen.
Probation 10/17/2018 to 10/17/2021

Field, Lauren Ashley
Columbia, MO
Licensed Practical Nurse 2009034918
Licensee's scheduled shift was from 8:00 a.m. to 6:00 p.m. The Staffing Coordinator was informed that licensee was repeatedly late to work, not staying for the entire shift, and having patient's family sign blank timesheets, which did not include beginning and end times. Licensee's timesheet reported arriving at 8:00 a.m. every day. Licensee was confronted by the Staffing Coordinator regarding the incidents, but denied the allegations. Licensee later sent an email stating she was sorry for her actions and understood that there may be consequences for her actions. On October 13, 2017, Licensee was terminated from the agency due to falsifying timesheets.
Probation 10/17/2018 to 10/17/2020

Zellmer, Brianna Marie
Saint Joseph, MO
Registered Nurse 2012021851
On or about January 14, 2018 a co-worker reported that one of her patient's medications had been removed from the Pyxis under Licensee's name. Licensee admitted that she had been diverting IV Dilaudid and Fentanyl from the hospital for personal use for approximately one (1) year.
Probation 10/06/2018 to 10/06/2023

Galvez, Kathy A
Saint Peters, MO
Registered Nurse 2018035109
On or about December 26, 2014, Licensee was arrested for Operating a Motor Vehicle While Intoxicated. Licensee received outpatient treatment at Connections Counseling from January 7, 2015, until March 2016. From July 25, 2015 until August 22, 2015, Licensee received inpatient treatment. On or about February 22, 2016, Licensee applied for licensure as a Registered Nurse with the Oregon State Board of Nursing. Licensee self-reported her DUI arrest and substance abuse treatment. On June 23, 2016, Licensee signed a Stipulated Order with the Oregon Board withdrawing her application due to failing to meet the Boards minimum 18 month sobriety requirement. The Stipulated Order became effective on July 13, 2016. On or about January 30, 2017, Licensee signed an Agreement to Practice with Conditions with the Washington State Department of Health. Licensees credential to practice as a registered nurse in the state of Washington was approved on February 8, 2017, provided that Licensee participate in the Washington Health Professional Services monitoring program based upon her history of alcohol use. Licensee was additionally granted the credential to practice as an advanced practice registered nurse practitioner in the State of Washington on or about March 6, 2017. On or

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about April 14, 2017, Licensee was granted licensure as a registered nurse and an advanced practice registered nurse by the Oregon State Board of Nursing provided Licensee attends the Oregon nurse monitoring program based upon her history of alcohol use. Licensee is compliant with both the Washington and Oregon monitoring programs. Licensee states her sobriety date is June 21, 2015, and she attends AA meetings two to three times per week.
Probation 09/24/2018 to 09/24/2021

Phillips, Alicia Shannon
Prairie Village, KS
Registered Nurse 2009034893
When questioned by her employer about discrepancies in a client's file, Respondent admitted to forging the signature of the patients' mother on three (3) occasions. Respondent stated that she forged the signatures because she was under time constraints and unable to get the signatures at the time of the patient visits. Respondent admitted to the Board's investigator that she had forged the mother's signature on the three (3) forms.
Probation 09/26/2018 to 09/26/2019

Carter, Lydia Catherine
New Madrid, MO
Licensed Practical Nurse 2009026211
On or about April 7, 2016, the Missouri Department of Health and Senior Services (DHSS) completed an investigation which showed that Licensee had submitted Nursing Visit Reports for multiple patients on multiple occasions for visits that she did not actually perform. The DHSS investigation found the following: Licensee falsified the Nursing Visit Report for patient R.D. on thirteen occasions; Licensee falsified the Nursing Visit Report for patient J.W. on sixteen occasions; Licensee falsified the Nursing Visit Report for patient S.R. on thirteen occasions; Licensee falsified the Nursing Visit Report for patient V.P. on one occasion; Licensee falsified the Nursing Visit Report for patient N.J. on seventeen occasions; Licensee falsified the Nursing Visit Report for patient V.D. on one occasion; Licensee falsified the Nursing Visit Report for patient S.T. on two occasions. When questioned, Licensee admitted to falsifying patient signatures and submitting Nursing Visit Reports for visits that she did not perform. Licensee was placed on the Employee Disqualification List (EDL) for a period of three years due to misappropriating funds of an in-home services client and falsifying documents verifying service delivery to an in-home services client.
Probation 09/11/2018 to 09/11/2020

Browning, Jennifer Irene
Auxvasse, MO
Registered Nurse 2010022745
On January 4, 2017, a patient's physician notified officials that patient's prescription for Percocet was replaced with Mucinex. Video surveillance showed the Licensee picking up the patient's prescription from the pharmacy. Surveillance then showed Licensee went to the breakroom where, outside the view of surveillance, Licensee replaced the Percocet with Mucinex. After returning from the breakroom, Respondent stapled the medication bag closed and then gave the Mucinex medication to the patient. A comprehensive automated dispending cabinet (ADC) user activity report was also reviewed, which showed discrepancies with documentation of administration, waste or return by the Licensee. Licensee also filled a prescription for another patient for Norco, then diverted the medication for her own personal use. When that patient went to fill their own prescription they were unable to do so because the pharmacy showed record that the patient had already had that prescription filled. Licensee was asked to submit to a for-cause urine drug screen on January 5, 2017. Licensee's urine sample was confirmed positive for the presence of hydrocodone, hydromorphone, alprazolam, oxycodone, and oxymorphone by the medical review officer on January 14, 2017. Licensee admitted to the Board's investigator that she had diverted narcotics for her own personal use.
Probation 09/04/2018 to 09/04/2023

Winsor, Sandra Dawn
Independence, MO
Licensed Practical Nurse 2008036737
On September 24, 2013, Respondent and the Oklahoma State Board of Nursing entered into a Stipulations, Settlement and Order (Order) finding that Respondent's Oklahoma nursing license was subject to discipline for multiple guilty pleas, including the following: Operating a Motor Vehicle While Under the Influence of Alcohol; Unlawful Possession of Marihuana; Assault, and; Driving While Intoxicated. Pursuant to the Order, Respondent was granted licensure in Oklahoma, subject to temporary suspension. The temporary suspension was to be set aside upon the Board's receipt of documentation of Respondent's acceptance into the Peer Assistance Program within 60 days of licensure. The Order also provided:
If Respondent is not accepted into the Peer Assistance Program within sixty (60) days of licensure, or having been accepted is terminated from the Program for any reason other than successful completion of Respondent's contract and treatment plan, Respondent's license is hereby revoked for a period of two (2) years.
Respondent failed to complete and submit documentation of the successful completion of the Peer Assistance Program, and Respondent's Oklahoma nursing license was subsequently revoked for two (2) years, effective December 16, 2013. At the disciplinary hearing, Respondent admitted that she is an alcoholic. At the hearing, Respondent also admitted to consuming alcohol when she travels to Oklahoma to visit her sister.
Probation 10/22/2018 to 10/22/2023

Younger, Rebekah Lynn
Saint Joseph, MO
Registered Nurse 2015023668
On February 20, 2018, Respondent pled guilty to the class D felony of Possession of Controlled Substance Except 35 Grams or Less of Marijuana/Synthetic Cannabinoid, in violation of õ579.015 RSMo., in the Circuit Court of Buchanan County, Missouri.
Probation 11/20/2018 to 11/20/2023

Moore, William DeVery
Grandview, MO
Licensed Practical Nurse 2018039138
On or about January 16, 2014, Licensee pled guilty to the felony offense of Bank Fraud. Licensee was given five (5) years probation and ordered to pay $41,908.99 in restitution.
Probation 10/25/2018 to 10/25/2020

Bernard, Ronald L
Sturgeon, MO
Registered Nurse 121378
Staff reported Licensee may be using narcotics in the workplace. Upon completion of a drug screen and returning to the facility, Licensee admitted to diverting Fentanyl. Licensee's urine sample was confirmed positive for the presence of Fentanyl. Licensee admitted to the Board's investigator that he diverted Fentanyl waste for his personal consumption and would waste saline instead of the excess Fentanyl. Licensee did not have a prescription or lawful reason to possess the Fentanyl he diverted.
Probation 11/09/2018 to 11/13/2018

REVOCATION

Nelson, Debra Lynn
O Fallon, MO
Licensed Practical Nurse 2012040150
On April 5, 2018, Respondent pled guilty to the class D misdemeanor of Stealing, Value Less Than 150.00 dollars, in the Circuit Court of Lincoln County, Missouri. Respondent was given a suspended imposition

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of sentence with two years of supervised probation. Respondents guilty plea was the result of the Respondent misappropriating medications from her employer.

Owens, Terrie L
Union, MO
Registered Nurse 086110
Respondent failed to check in with NTS on ten days. On April 11, 2017; August 15, 2017; October 24, 2017; April 6, 2018; May 15, 2018; and, June 4, 2018, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. On February 29, 2016, Respondent reported to a collection site and submitted the required sample which showed a low creatinine reading. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of October 16, 2015; January 18, 2016; October 17, 2016; April 17, 2017; July 17, 2017; and June 16, 2018. Additionally, the Board received untimely employer evaluations on January 25, 2017 for the January 16, 2017 due date; on November 3, 2017 for the October 16, 2017 due date; and on January 30, 2018 for the January 16, 2018 due date. To date, the Board has only received timely employer evaluations or statements of unemployment by three of the twelve due dates. On April 11, 2018, the Board received a nursing performance evaluation form for Respondent that indicated an evaluation or counseling session had been held within the past three months. It also indicated that the employer was unsure as to whether Respondent was maintaining abstinence from all mood-altering chemicals, pointing to a counseling session held on April 5, 2018. On April 5, 2018, Respondent received counseling for working while impaired. Respondent was reportedly drooling, had slurred speech, had food on her face and in her teeth, and had mud on her clothing. She was told not to return to work until she saw her physician.

Brown, Jaundainne Rochelle
Raymore, MO
Registered Nurse 2009005406
From April 7, 2017 until the filing of the Complaint, Respondent failed to check in with NTS at all on eight days, and failed to check in with NTS within the required time window on fifteen days. In addition, on September 27, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 20.0 is deemed a diluted sample and considered a failed alcohol test by the Board and a violation of the terms of probation. On June 28, 2018, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription or other lawful reason to possess amphetamine when she tested positive on June 28, 2018.

Voyles, Sabrina Mashell
Rockaway Beach, MO
Licensed Practical Nurse 2003014344
Respondent has never completed the contract process with NTS. Respondent did not attend the meeting or contact the Board to reschedule the meeting.

Tierney, Jane Ann
Saint Louis, MO
Registered Nurse 2014006646
From August 5, 2016, the date the previous probation violation complaint was filed, until the filing of the Complaint on July 11, 2018, Respondent failed to call or check in with NTS on six (6) days. Further, on May 2, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on two (2) occasions, October 27, 2016 and February 3, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On May 14, 2018, Respondent reported to a collection site to provide a sample, and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol, and Ethyl Sulfate (EtS), a metabolite of alcohol. The Board did not receive an updated chemical dependency evaluation by the documentation due date of September 4, 2017. The Board did not receive evidence of continued support group attendance by the quarterly due date of September 4, 2017.

McLendon, Glenn William
Springfield, MO
Registered Nurse 2006004784
On January 15, 2018, Respondent submitted a urine sample for a reasonable cause drug screen at his employer. That sample tested positive for the presence of Fentanyl. Fentanyl is a controlled substance pursuant to õ195.017.4(2)(i) RSMo. Respondent does not have a current, valid prescription for Fentanyl.

VOLUNTARY SURRENDER

Bernard, Ronald L
Sturgeon, MO
Registered Nurse 121378
Licensee voluntarily surrended his license effective November 14, 2018.

Wagner, Michael Thomas
Lawrence, KS
Registered Nurse 2017012690
Licensee voluntarily surrendered his Missouri nursing license effective November 5, 2018.

Love, Daren C
Jefferson City, MO
Registered Nurse 126455
Licensee Voluntarily Surrendered
Voluntary Surrender 10/30/2018 to

Enowmba, Ashu Arrey
Kansas City, MO
Registered Nurse 2012023836
On or about July 7, 2018, Licensee entered into an Agreed Order (Order) with the Texas Board of Nursing finding that Licensee's privilege to practice was subject to discipline and would be sanctioned. The Order became effective on July 11, 2018.

Roberson, Jamie Lynn
Canton, MO
Licensed Practical Nurse 2013036688
On April 12, 2018, the Iowa Department of Inspections and Appeals, Division of Administrative Hearings, issued its Proposed Decision affirming the decision of the Iowa Department of Inspection and Appeals, Health Facilities Division, placing Licensee's name on the dependent adult abuse registry for exploiting a dependent adult. The Proposed Decision became effective on April 27, 2018.

Rodriquez, Lori A
Gower, MO
Registered Nurse 136272
On March 9, 2016, Respondent withdrew Fentanyl from the Pyxis for a patient who was not assigned to her. Hospital management conducted an investigation into Respondent's narcotic administration for the previous thirty (30) days. On February 11, 2016, Respondent withdrew 100 mcg of Fentanyl for patient WC at 08:29, 08:30, and 10:57 for a total of 300 mcg of Fentanyl. Respondent documented the administration of 100 mcg of Fentanyl to patient WC at 10:26 and 11:00 for a total of 200 mcg of Fentanyl. Respondent failed to document the administration, waste, or return of the remaining 100 mcg of Fentanyl. On February 18, 2016, Respondent withdrew 100 mcg of Fentanyl for patient identified as BB.O. at 08:48. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. On February 18, 2016, Respondent withdrew a Fentanyl/Bupivicaine epidural for patient identified as BB.O. at 08:48. Respondent failed to document the administration, waste, or return of the Fentanyl/Bupivicaine epidural. On February 18, 2016, Respondent withdrew 100 mcg of Fentanyl for patient CO at 14:52. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. On February 18, 2016, Respondent withdrew 4 mg of Morphine for patient CO at 13:23. Respondent failed to document the administration, waste, or return of the 4 mg of Morphine. On February 29, 2016, Respondent withdrew 100 mcg of Fentanyl for patient SW at 14:08. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. On March 2, 2016, Respondent withdrew 100 mcg of Fentanyl for patient MJ at 13:16. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. On March 8, 2016, Respondent withdrew 100 mcg of Fentanyl for patient SRW at 11:40. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. On March 9, 2016, Respondent withdrew 100 mcg of Fentanyl for patient ST at 09:02. Respondent failed to document the administration, waste, or return of the 100 mcg of Fentanyl. Respondent failed to properly document what happened to controlled substances that were in her possession.

DeLap, Melissa D
Columbia, MO
Registered Nurse 140313
On or about August 20, 2018, Licensee entered a guilty plea to healthcare fraud. Pursuant to the plea agreement, Licensee agreed to surrender her nursing license within six (6) months. Licensee was employed as a community registered nurse and provided services to Medicaid beneficiaries participating in individualized supporting living programs. Resident C.D. and three other residents resided in Home. Pursuant to Medicaid guidelines, Licensee was required to provide services as a community registered nurse for resident C.D. and the three other residents on a monthly basis and document those visits. Licensee documented making monthly visits and performing assessments on resident C.D. and the three other residents from at least September 2016 through March 2017. Resident C.D. died approximately in early September 2016. His body was discovered in March 2017. Licensee submitted false statements in order to be paid. Licensee admitted to falsely documenting visits to patient C.D. for financial gain.

Hoffmann, Lynn Marie
Saint Louis, MO
Registered Nurse 2009024663
Licensee voluntarily surrendered her Missouri nursing license effective September 21, 2018.

Disciplinary Actions**

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

☐ RN ☐ APRN ☐ LPN

Missouri License Number _____ Last 4 Digits of Social Security Number _____

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed) _____ First Name (Printed) _____

NEW INFORMATION

Last Name _____ First Name _____ Middle Name _____

(_____)_____ (_____)_____ _____

Daytime Telephone Number Alternate Phone Number E-mail Address

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ I declare _____ as my primary state of residence effective _____.
(primary state of residence) (effective date)

☐ I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

Information on the Nurse Licensure Compact can be found at www.ncsbn.org/nlc.htm
In accordance with the Nurse Licensure Compact **"Primary State of Residence"** is defined as the state of a person's declared fixed, permanent and principal home for legal purposes; domicile. Documentation of primary state of residence that may be requested (but not limited to) includes:

- Driver's license with a home address
- Voter registration card displaying a home address
- Federal income tax return declaring the primary state of residence
- Military Form no. 2058 – state of legal residence certificate
- W-2 from US Government or any bureau, division or agency thereof indicating the declared state of residence

Proof of any of the above may be requested.

When your primary state of residence is a non-compact state, your license will be designated as a single-state license valid only in Missouri.

When your primary state of residence is a compact state other than Missouri, your Missouri license will be placed on inactive status and you can practice in Missouri based on your unrestricted multi-state license from another compact state.

I solemnly declare and affirm, that I am the person who is referred to in the foregoing declaration of primary state of residence; that the statements therein are strictly true in every respect, under the pains and penalties of perjury.

→_____ _____

Signature ***(This form must be signed)*** Date

Complete, SIGN and Return to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 Or Fax to 573-751-6745 or Scan and Email to nursing@pr.mo.gov

Nurse Practitioners

A Solution to America's Primary Care Crisis

Peter Buerhaus

Executive Summary

For the past few decades, the United States has not produced enough primary care physicians. Moreover, too few physicians practice in rural and medically underserved areas, and the number of people lacking adequate access to primary care has increased. Meanwhile, studies have piled up pointing to the high quality of care that nurse practitioners (NPs) provide, and increasing numbers of policy-influencing bodies have recommended expanding the use of NPs in primary care. Yet, barriers to the expanded use of NPs persist, and, consequently, tens of millions of Americans lack adequate access to primary care services. This report describes and integrates new evidence from a research program focused on the primary care workforce, NPs' role in primary care, and the potential for NPs to help solve the problem of Americans' access to quality primary care.

Among other things, the research summarized in this report establishes that it is unrealistic to rely on the physician workforce alone to provide the primary care Americans need, particularly for Americans in rural areas, who are generally older, less educated, poorer, and sicker. Many primary care physicians are expected to retire over the next decade, while demand is increasing for primary care. So current shortages of primary care are projected to worsen, with even fewer physicians practicing in rural areas. And as the proportion of physicians who are married to highly educated spouses increases, the already formidable challenges of attracting physicians to Health Professional Shortage Areas will become even more daunting.

Our findings examine trends in the supply of NPs and physicians, showing that the NP workforce has increased dramatically and is projected to continue growing while the physician workforce will grow minimally. Further, we find, as do other studies, that compared to primary care medical doctors, primary care nurse practitioners (PCNPs) are more likely to practice in rural areas, where the need for primary care is greatest.

Our research shows that people living in states with laws that reduce or restrict NPs' scope-of-practice had significantly less access to PCNPs. This finding indicates that such state regulations have played a role in impeding access to primary care. This alone should be cause for concern among policymakers seeking to improve public health.

Using different data and methods, the studies described in this report consistently show that NPs are significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians. NPs, whether they work independently of primary care physicians or with them, are more likely to accept Medicaid recipients, provide care for the uninsured, and accept lower payments than are physicians who do not work with NPs. Another major finding is that, after controlling for differences in patient severity and sociodemographic factors, the cost of care provided to Medicare beneficiaries by NPs was significantly lower than primary care provided by physicians. Even after accounting for the lower payment NPs receive relative to physicians, the cost of NP-provided care was still significantly lower.

However, the viability of increased reliance on NPs still depends on the simple question at the core of this project: Can NPs provide health care of comparable quality to that provided by primary care physicians? Our studies showed that beneficiaries who received their primary care from NPs consistently received significantly higher-quality care than physicians' patients in several respects. While beneficiaries treated by physicians received slightly better services in a few realms, the differences were marginal. These results held when vulnerable populations of Medicare beneficiaries were analyzed separately and compared to those cared for by physicians, aligning with the findings of many other studies conducted over the past four decades.

Furthermore, state-level NP scope-of-practice restrictions do not help protect the public from subpar health care. Analysis of different classifications of state-level scope-of-practice restrictions provided no evidence that Medicare beneficiaries living in states that imposed restrictions received better-quality care. Some physicians and certain professional medical associations have justified their support for state regulations to limit NP scope-of-practice on the grounds that they are necessary to protect the public from low-quality providers and to assert that physicians must be the leaders of the health care team. We found no evidence to support their claim.

Further, our analysis showed that Medicare beneficiaries living in states with reduced or restricted NP scope-of-practice were more likely to use more resources than were beneficiaries in states without such restrictions. This indicates that these beneficiaries had less access to the positive contributions of NPs.

Despite this body of evidence, our national survey of primary care clinicians revealed that around one-third of primary care physicians believe increasing the number of NPs would impair the safety and effectiveness of care. This could indicate that physicians are not aware of the findings of research. Or alternatively, it is an excuse for a barrier to entry, meant to protect some physicians' narrow interests at the expense of accessible primary care for many Americans who need it.

The evidence leads to three recommendations that can help overcome the growing challenges facing the delivery of primary care in the US. First, private policymakers such as hospital boards and credentialing bodies should allow NPs to practice to the fullest extent of their training and ability. Second, physicians must understand that NPs provide quality health care to those in need. NPs and physicians should work together to build relationships that allow for their respective roles and practices to evolve, respecting each other's strengths and ultimately leading to a workforce that is more responsive to communities' health needs. Third, public policymakers should remove restrictions on NPs that limit their scope-of-practice.

A Solution To America's Primary Care Crisis

The doctors are fighting a losing battle. The nurses are like insurgents. They are occasionally beaten back, but they'll win in the long run. They have economics and common sense on their side.
- Uwe Reinhardt, Professor of Economics at Princeton University[1]

Nearly 30 years ago, in 1991, well-known physician and thought leader Gordon Moore wrote in the *Journal of the American Medical Association*: "Primary care is the most affordable safety net we can offer our citizens."[2] The National Academy of Medicine defines primary care as "the provision of *integrated, accessible health care services* by clinicians who are accountable for addressing a large majority of personal health care needs, developing a *sustained partnership* with *patients,* and practicing in the *context of family and community.*"[3]

Primary care clinicians typically treat a variety of conditions, including high blood pressure, diabetes, asthma, depression and anxiety, angina, back pain, arthritis, thyroid dysfunction, and chronic obstructive pulmonary disease. They provide basic maternal and child health care services, including family planning and vaccinations. Primary care lowers health care costs, decreases emergency department visits and hospitalizations, and lowers mortality.[4]

Primary care is a crucial component of American health care, but it faces steep challenges, beginning with ever-increasing demand for primary care services. Demand for primary care has been growing for decades and is expected to increase.[5] The Affordable Care Act (ACA) expanded the number of people with health insurance and increased access to primary care services by eliminating patient cost sharing for a wide array of preventive services and screenings.[6]

Demand for primary care will continue to increase as the 76 million baby boomers age into the Medicare program. Currently, 54 million people are enrolled in Medicare, the nation's health insurance program for citizens 65 and older and those with end-stage renal disease and other qualifying disabilities. As baby boomers age, Medicare enrollment is expected to increase to 80 million by 2030.[7]

Not only are baby boomers expected to live longer than previous generations, but also the prevalence of multiple chronic diseases is increasing. By 2030, four in 10 baby boomers are expected to have heart disease or diabetes, and 25 percent will have cancer. The percentage of those enrolled in Medicare with three or more chronic diseases will increase from 26 percent in 2010 to 40 percent in 2030.[8] Add to this the increasing number of people with Alzheimer's disease (a leading cause of death in the US) and other dementias, and it is clear that the demand for primary care will increase in coming decades, especially the need for care geared toward the elderly.[9]

If the growth in demand for primary care is a challenge, the current and projected shortages of primary care physicians only make matters worse. The Association of American Medical Colleges (AAMC) estimates that by 2030 we will have up to 49,300 fewer primary care physicians than we will need (an even-larger estimate than the AAMC reported in 2016).[10] Many specialist physicians also provide considerable primary care, but projected shortages of such physicians (by as many as 72,700 by 2030) only adds to concerns over the adequacy of the primary care physician workforce.[11] Despite decades of effort, the graduate medical education system has not produced enough primary care physicians to meet the American population's needs.[12]

When geographic distribution of primary care medical doctors (PCMDs) is taken into account, the problem begins to feel like a crisis. In 2018 the federal government reported 7,181 Health Professional Shortage Areas in the US and approximately 84 million people with inadequate access to primary care, with 66 percent of primary care access problems in rural areas.[13]

Thankfully, there is a solution. Increasingly, researchers, workforce analysts, and organizations that influence health policy support expanding the role of nurse practitioners (NPs) to fill the void left by the lack of primary care physicians and to improve the uneven geographic distribution of primary care. This report presents results from original research projects that support this view and document the evidence base for an expanded role for NPs in remedying these pressing and growing access problems.

Nurse Practitioners: A Regulated Solution

After practicing as a professional nurse for several years, many registered nurses acquire advanced clinical knowledge, training, and patient care responsibilities to become nurse practitioners. In the words of the American Association of Nurse Practitioners (AANP): "All NPs must complete a master's or doctoral degree program, and have advanced clinical training beyond their initial professional registered nurse preparation."[14] Didactic and clinical courses prepare NPs with specialized knowledge and clinical competency to practice in primary care, acute care, and long-term health care settings. NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans.[15]

They also prescribe medications, including controlled substances, in all 50 states and DC, and 50 percent of all NPs have hospital-admitting privileges.[16]

The AANP reports that the nation's 248,000 NPs (87 percent of whom are prepared in primary care) provide one billion patient visits yearly.[17] NPs are prepared in the major primary care specialties—family health (60.6 percent), care of adults and geriatrics (21.3 percent), pediatrics (4.6 percent), and women's health (3.4 percent)—and provide most of the same services that physicians provide, making them a natural solution to the physician shortage.[18] NPs can also specialize outside primary care, and one in four physician specialty practices in the US employs NPs, including psychiatry, obstetrics and gynecology, cardiology, orthopedic surgery, neurology, dermatology, and gastroenterology practices.[19]

Further, NPs are paid less than physicians for providing the same services. Medicare reimburses NPs at 85 percent the rate of physicians, and private payers pay NPs less than physicians.[20] On average, NPs earn $105,000 annually.[21]

NPs' role in primary care dates to the mid-1960s, when a team of physicians and nurses at the University of Colorado developed the concept for a new advanced-practice nurse who would help respond to a shortage of primary care at the time.[22] Since then, numerous studies have assessed the quality of care that NPs provide (see Appendix A), and several policy-influencing organizations (such as the National Academy of Medicine, National Governors Association, and the Hamilton Project at the Brookings Institution) have recommended expanding the use of NPs, particularly in primary care.[23] Even the Federal Trade Commission recognizes the role of NPs in alleviating shortages and expanding access to health care services.[24] Most recently, the US Department of Veterans Affairs amended its regulations to permit its nearly 5,800 advanced-practiceregistered nurses to practice to the full extent of their education, training, and certification regardless of state-level restrictions, with some exceptions pertaining to prescribing and administering controlled substances.[25]

Nonetheless, physicians have met such efforts with mixed response. Many physicians favor the use of NPs, at least in theory. A 2012 national survey of PCMDs found that 41 percent reported working in collaborative practice with primary care nurse practitioners (PCNPs) and 77 percent agreed that NPs should practice to the full extent of their education and training. Additionally, 72.5 percent said having more NPs would improve timeliness of care, and 52 percent reported it would improve access to health services.

However, about one-third of PCMDs said they believe the expanded use of PCNPs would impair the quality and effectiveness of primary care.[26] The survey also found that 57 percent of PCMDs worried that increasing the supply of PCNPs would decrease their income, and 75 percent said they feared NPs would replace them.

Although PCMDs generally favor using NPs at current levels, they seem to fear that increased PCNP-based care will usurp them or make them obsolete. These PCMDs are rationally self-interested, and understandably so. But for the good of patients around the country, hospital boards and state lawmakers should prioritize patients over PCMDs' concerns and relieve the shortage of primary care providers with PCNPs.

Current Restrictions on PCNP Practice

To protect the interests of PCMDs, the American Medical Association, American Academy of Family Physicians, and some state and county medical associations favor state-level legal restrictions on the services that an NP may provide, whether in primary care or acute care delivery settings. In fact, many states impose varying degrees of legal restrictions on NPs, which the AANP has classified as follows.[27]

- **Full Practice.** State practice and licensure laws allow all NPs to evaluate patients, diagnose patients, order and interpret diagnostic tests, and initiate and manage treatments—including prescribing medications and controlled substances—under the exclusive licensure authority of the state board of nursing. The National Academy of Medicine and National Council of State Boards of Nursing recommend this model.
- **Reduced Practice.** State practice and licensure laws reduce NPs' ability to engage in at least one element of NP practice. State law limits the setting of one or more elements of NP practice or requires a career-long regulated collaborative agreement with another health care provider in order for the NP to provide patient care.
- **Restricted Practice.** State practice and licensure laws restrict NPs' ability to engage in at least one element of NP practice. State law requires career-long supervision, delegation, or team management by another health care provider in order for the NP to provide patient care.

Table 1. State-Level Scope-of-Practice Regulatory Restrictions on Nurse Practitioners, 2018

Full Practice	Reduced Practice	Restricted Practice
Alaska	Alabama	California
Arizona	Arkansas	Florida
Colorado	Delaware	Georgia
Connecticut	Illinois	Massachusetts
District of Columbia	Indiana	Michigan
Hawaii	Kansas	Missouri
Idaho	Kentucky	North Carolina
Iowa	Louisiana	Oklahoma
Maine	Mississippi	South Carolina
Maryland	New Jersey	Tennessee
Minnesota	New York	Texas
Montana	Ohio	Virginia
Nebraska	Pennsylvania	
Nevada	Utah	
New Hampshire	West Virginia	
New Mexico	Wisconsin	
North Dakota		
Oregon		
Rhode Island		
South Dakota		
Vermont		
Washington		
Wyoming		

Source: American Association of Nurse Practitioners, "State Practice Environment," https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-typerestricted-practice.

Over the past two decades, the trend among states has been to remove scope-of-practice restrictions.[28] As shown in Table 1, in 2018, 23 states allowed the full practice of NPs, 16 states reduced certain areas of NP practice, and 12 states were classified as restricting NP practice.[29]

These restrictions infringe on the clinical activities NPs are trained to perform. In 1992, Yale Law School Associate Dean Barbara Safriet made a compelling case for increasing NPs' roles in primary care:

> Advanced practice nurses have demonstrated repeatedly that they can provide cost-effective, high-quality primary care for many of the neediest members of society, but their role in providing care has been has been [*sic*] severely limited by restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement. Eliminating these restriction [*sic*] would enable advanced practice nurses to increase access to health care while preserving quality and reducing costs.[30]

Safriet contends that scope-of-practice restrictions on NPs impede their ability to practice to the full extent of their education and training, which is undesirable for both NPs and PCMDs. Eighteen years later, she again argued for removing these regulatory obstacles to allow Americans better access to care at a more affordable cost and to reform the health care regulatory framework to enhance all providers' abilities and competencies.[31] This report builds on Safriet's argument and adds a potential framework for reform that would allow NPs to best practice according to their abilities and allow Americans more affordable access to health care, especially in rural areas.

Research

The concept of expanding the use of NPs and removing restrictions on their practice has gained traction since the ACA was being developed. Health workforce analysts have long been concerned with the shortage of primary care physicians and the persistent inability of graduate medical education programs to produce enough physicians to make up the difference. Indeed, the ACA contains many provisions aimed at addressing these and other workforce-supply problems.

One such provision was the establishment of the National Health Care Workforce Commission to advise Congress and the administration on national health workforce policy. I was appointed to the commission and agreed to serve as its chairman. Anticipating that the commission would be asked to address the shortage of primary care physicians, I assembled teams of investigators to assess the feasibility and desirability of expanding PCNPs' roles in primary care.

The workforce issues discussed most frequently among health policymakers, members of Congress, state legislators, and their staffs concern the quality and costs of NPs and their potential to alleviate the shortage of primary care physicians. These issues guided the assessment of whether NPs can fix the labor supply problems among primary care providers. The specific questions on the minds of the policy community included:

- Geographically, where do primary care physicians practice, and where do PCNPs practice?
- How large are current shortages of primary care physicians? Will the primary care physician workforce increase or decrease in the future?
- Will the NP workforce grow in the future?
- Are PCNPs willing to accept people enrolled in Medicaid?
- How do the services that PCNPs provide compare to the services that PCMDs provide?
- Are there differences in the characteristics of people who are treated by PCNPs and PCMDs?
- What is the potential for NPs to increase access to primary care and help alleviate shortages and uneven distribution of primary care physicians?
- Do state-level regulatory restrictions placed on NPs limit Americans' access to primary care?

The answers to the above questions will help bring us toward a framework for more effective primary care.

This report describes key results of research conducted since 2011 that aimed to answer these questions. It integrates the studies' findings with the results of other published research and makes recommendations for both public and private policymakers on improving the capacity of the nation's primary care workforce. The results of these studies are presented as further proof of the benefits of using NPs to provide more Americans in more places with the primary care they need.

Solutions: Study Results

To address these questions, the research was divided into three areas of analysis: (1) assessing the contributions of NPs providing primary care, (2) projecting the supply of physicians and NPs while assessing the geographical disparities of the primary care workforce, and (3) revealing perceptions of the PCNP workforce. Each area focused on a different element of primary care shortages and how well NPs could address them. The focuses of each of these areas parallel the questions we set out to answer:

- The analysis of NP contributions identified the types, quantity, costs, and quality of primary care that NPs and physicians provide to Medicare beneficiaries. It also assessed whether state level NP scope-of-practice restrictions affect the quality of primary care that Medicare beneficiaries receive.
- The projections and geographical analyses examined the geographic locations of the primary care physician and NP workforce, investigated barriers physicians face in locating their practice in rural locations, and projected the future supply of physicians and NPs.

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- Assessing perceptions of NPs involved conducting a national survey of PCMDs and PCNPs to identify their practice characteristics and examine their attitudes, knowledge, and behavior on various themes, including shortages of primary care professionals, expanding the number of PCNPs, quality of care provided by PCNPs, responsibility for providing specific services and procedures, and career recommendations.

The most obvious and crucial question is whether NPs can provide the same quality and types of care that physicians currently provide. Driving down the cost of and increasing accessibility to health care is a worthwhile goal. But if the quality of primary care provided by PCNPs is not up to par, they present a far less attractive remedy.

For these reasons, this report begins with the findings of the NP analysis team, which asked: What are the types, costs, and quality of primary care services provided by PCNPs, and how do they compare to the primary care provided by PCMDs? Are there differences in the characteristics of people treated by PCNPs versus PCMDs? And do state-level scope-of-practice restrictions on PCNPs affect the quality of primary care?

While hundreds of studies have assessed different ways that NPs contribute to providing primary care, there are lingering questions about the costs and quality of NP-provided care, questions not fully answered by prior studies. Consequently, it is difficult to generalize the results from many of these studies to broader populations, let alone make apples-to-apples comparisons between the care provided by NPs and physicians. In all, despite the large number of studies that showed favorable results for the care delivered by NPs (see Appendix A), there is room to learn more, improve and expand the measurement of primary care, make more direct comparisons between primary care clinicians, use different data to enable better generalization of results, and apply advanced statistical techniques to overcome methodological shortcomings.

What Types of Primary Care?

The analysis of NP contributions to primary care began with using Medicare claims and other Medicare administrative data to identify the number and distribution of PCNPs throughout the US who billed for care provided to Medicare beneficiaries. This was then used to describe the types, quantities, and overall costs of services that PCNPs provide and compare them to those that PCMDs provide.[32]

Results showed that in 2008 approximately 45,000 NPs were providing services to Medicare beneficiaries and billing under their own national provider identification (NPI) number. NPs in rural states had the highest rates of billing under their own NPI numbers. Findings also indicated that just over 80 percent of the payments that both PCNPs and PCMDs received were for evaluation and management services (i.e., new patient and established patient office visits, home visits, and nursing home visits). Relative to PCMDs, NPs had a significantly greater proportion of payments associated with procedures (9.1 vs. 4.6 percent), billed for fewer tests (4.8 vs. 5.8 percent), and had a lower proportion of their payments associated with imaging (1.3 vs. 3.9 percent). Overall, findings indicated there was great overlap in the types of primary care provided.

Who—what kind of American—was receiving PCNP-provided primary care through Medicare? Compared to beneficiaries receiving primary care from PCMDs, beneficiaries receiving primary care from PCNPs were significantly more likely to be female, younger, American Indian, nonwhite, dually eligible for Medicare and Medicaid (an important proxy for poverty), and qualified for Medicare due to a disability.

And where are these patients and providers located? The study revealed that PCNPs caring for Medicare beneficiaries were significantly more likely to practice in a federally designated Health Professionals Shortage Area and in rural areas compared to PCMDs. These findings are supported by the results of other investigators (see Appendix A), who have also found that NPs provide primary care to vulnerable populations and that PCNPs are more likely to practice in rural and underserved areas.

Costs of Primary Care

Because enrollment in Medicare will expand rapidly as baby boomers age, total Medicare spending will increase substantially in the years ahead. Consequently, providing access to health care without bankrupting the Medicare program is a growing concern.

The next study was undertaken to determine whether PCNPs can help address this concern, aiming to compare the costs of PCNPs and PCMDs providing primary care to Medicare beneficiaries. The study analyzed Medicare payment claims during a 12-month period (2010), including claims for inpatient and outpatient care. It examined five measures of the cost of care, adjusted for differences in payment rates and severity of a patient's health condition.[33]

Across all five measures, the study found that the cost of PCNP-provided care ranged between 11 percent and 29 percent less than the cost of PCMD-provided care. The gap was most pronounced for evaluation and management services—composing 80 percent of claims that PCMDs and PCNPs bill to Medicare. Beneficiaries treated by PCNPs who received such services cost Medicare 29 percent less than beneficiaries who received their primary care from PCMDs. The large differences in costs between PCNPs and PCMDs persisted even after taking into account that Medicare pays NPs at 85 percent of the rate of physicians for the same services.

Due to limitations inherent in using claims data, we could not fully investigate the reasons for the differences in costs. But we believe they may be explained in part by differences in the style of NP practice, as NPs tend to provide more holistic care relative to the more disease-and-cure orientation of many physicians. Preliminary evidence from ongoing analysis also suggests that PCNPs order about one-third fewer services, and they are more likely than physicians to use less expensive services.[34] Of course, if that reflected decreased quality of care, it would be a major problem for a proposal to expand NP practice.

As noted in Appendix A, this study is not the first to find that NPs provide cost-effective care.

Quality of Care

While numerous studies have concluded that NP-provided care is comparable and in some cases better than PCMD-provided care (see Appendix A), some of these studies analyzed a limited number of clinical conditions, did not adequately control for patient-selection biases and disease severity, and assessed quality measures over brief time periods, which makes it difficult to generalize results to broader populations. To address these concerns, the next study used national Medicare claims data from 2012 and 2013 to assess 16 indicators of the quality of primary care that PCNPs and PCMDs provided to Medicare beneficiaries. To include beneficiaries who may have received care by a team of PCNPs and PCMDs, the analysis covered a third group of beneficiaries who had received primary care services from both types of clinicians over a 12-month period.[35]

Across all five measures, the study found that the cost of PCNP-provided care ranged between 11 percent and 29 percent less than the cost of PCMD-provided care.

Overall, study findings indicated that specific types of care were better when provided by PCNPs, and others were better when provided by PCMDs. For example, Medicare beneficiaries who received primary care from PCNPs were less likely than those cared for by PCMDs to have preventable hospital admissions, all-cause hospital readmissions within 30 days of being discharged, inappropriate emergency department visits, and low-value MRIs associated with low back pain. On the other hand, beneficiaries who received their primary care predominantly from PCMDs were more likely to receive slightly more of recommended chronic disease management services and cancer screenings (such as mammography screenings for breast cancer and colonoscopies for colorectal cancer).

The third group of beneficiaries, which received primary care from both PCNPs and PCMD, was expected to have received higher-quality care than those who received care from either a PCNP or PCMD alone. However, results indicated that in only one measure was primary care improved: cancer screening. This suggests that the care these beneficiaries received was fragmented and not well coordinated.

Quality of Care Provided to Vulnerable Medicare Beneficiaries

As noted above, the first study using Medicare claims data found that PCNPs were significantly more likely than PCMDs to provide primary care to beneficiaries who had a disability or who were dually eligible for Medicaid and Medicare, a strong indicator of poverty.[36] With approximately 38 million Americans living with disabilities and several million in poverty, providing high-quality health care at a reasonable cost to the poor and disabled is a major and growing challenge.[37]

Medicare and Medicaid often work in tandem to pay for dually eligible Americans. This kind of health care is disproportionately expensive: Dually eligible beneficiaries make up 20 percent of the Medicare population, but they account for 34 percent of Medicare spending.[38] They are also at increased risk of serious health problems, as they are more likely to have multiple comorbidities, such as diabetes, chronic lung disease, and Alzheimer's disease, and to self-report lower health status.[39]

For all these reasons, the need for effective and cost-efficient solutions for primary care is particularly salient for dually eligible patients, whether disabled or simply low income. People with disabilities are less likely to receive recommended preventive care such as screenings for breast and cervical cancer.[40] On average, people with disabilities receive differential treatment for cancer and are more likely to receive potentially inappropriate medications.[41]

Similarly, low-income patients face significant access barriers to care and receive fewer screenings (such as colonoscopies) and preventive services (such as vaccinations).[42]

Could increased practice by PCNPs help remedy this inequity? This question was addressed by using 2012 and 2013 Medicare claims data to identify and compare the quality of care provided by PCNPs and PCMDs and received by beneficiaries in three subpopulations: (1) those who initially qualified for Medicare based on a disability, (2) dually eligible beneficiaries, and (3) beneficiaries who qualified initially by having a disability and were also dually eligible for Medicare and Medicaid.[43] The quality of primary care that these subpopulations received was examined across the same four domains of primary care noted above: chronic disease management, the incidence of adverse outcomes, preventable hospitalizations, and cancer screenings.

Results showed that when PCNPs cared for Medicare beneficiaries who were dually eligible or qualified for Medicare due to a disability, the beneficiaries had similar results to the larger study of Medicare beneficiaries reported above. Specifically, these vulnerable

Medicare beneficiaries had a lower risk of preventable hospitalizations and emergency department use than those cared for by PCMDs. They also used fewer of other health care resources such as low-value imaging for low back pain. In addition, being managed by a PCNP helped beneficiaries in the area of chronic disease management, as these beneficiaries were no less likely than those treated by PCMDs to receive health care services consistent with established guidelines.

However, diabetic patients across these subpopulations who were cared for by PCNPs were less likely than those cared for by PCMDs to have eye screenings. The subpopulations served by NPs also received fewer cancer screenings.[44] These findings may be explained by unmeasured differences in patient characteristics, preferences for clinician type, clinician practice style, geographical access to screening technology (such as ease of obtaining mammograms in rural areas), care delivery patterns, organizational characteristics, and performance incentives that could not be measured and analyzed in the Medicare claims data.

Overall, the study's results suggest that increasing PCNP involvement in care could be a key policy strategy to expand access to primary care at a lower cost while not compromising quality for Medicare's most vulnerable beneficiaries.

Forecasts of Primary Care Workforce Supply and Location

The key findings of the studies we conducted, briefly summarized in this section, are:

- On the eve of the 2014 ACA insurance expansions, rural areas throughout the country had the highest numbers of uninsured people, particularly in non-Medicaid-expanding states.
- PCNPs, though fewer in number than PCMDs, are more likely to practice in rural areas than are physicians.
- People living in states that do not restrict NP scope-of-practice had significantly greater geographic access to primary care.
- Between 2016 and 2030, the size of the NP workforce will increase dramatically, growing 6.8 percent annually, compared to 1.1 percent growth of the physician workforce. Combined, the physician and NP workforce will increase by approximately 400,000 by 2030. NPs will account for 61 percent of this growth (240,000 workers).
- The number of physicians practicing in rural areas has been decreasing since 2000, and this decline will continue through 2030 while rural populations age and need more health care.
- The proportion of physicians married to highly educated spouses has grown dramatically over the past 50 years, and these physicians are significantly less likely to practice in rural shortage areas.
- The supply of physicians practicing in rural areas decreased by 15 percent between 2000 and 2016 and is forecasted to decline further through 2030.

Can PCNPs help remedy the acute shortage of primary care in rural areas? The first study conducted to answer this question focused on identifying the geographic location of individuals who were newly eligible for the ACA's insurance expansions starting in January 2014. It assessed whether geographic access to primary care clinicians differed across urban and rural areas and across states with varying scope-of-practice laws.[45] The study also constructed a detailed understanding of the geographic location of primary care clinicians—physicians, NPs, and physician assistants(PAS)—on the eve of the ACA's insurance expansions.

Findings showed that, in 2014, large urban areas had 131 uninsured people per primary care clinician, whereas the most rural areas of the country had 357 uninsured people per primary care clinician. The number of uninsured was considerably higher in the states that did not expand Medicaid enrollment as of January 2015: Rural areas of non-expanding states averaged 441.1 uninsured per primary care clinician compared with 192.8 per primary care clinician in similar areas of Medicaid-expanding states. Furthermore, and importantly for our policy prescriptions, primary care physicians were more likely to be concentrated in urban areas, while PCNPs were more likely to be located in rural areas with more uninsured people.

Finally, geographic access to primary care was significantly higher in states that did not restrict NP scope-of-practice compared to those that did: 63 percent of people living in nonrestrictive states had geographic access to counties with a high capacity of primary care clinicians compared to 34 percent of people living in states that restricted NP scope-of-practice. Results also showed that states with restricted NP scope-of-practice had 40 percent fewer NPs compared to those without. These findings suggest that lifting state-level scope-of-practice restrictions on NPs would, over time, increase access to primary care, particularly in rural areas. As shown in Appendix A, other studies have also reported similar findings.

Two additional economic studies focused on projecting the future national supply of physicians and NPs. Applying a peer-reviewed cohort supply model developed in 2000 and used in many studies of the nurse and physician workforces, we analyzed trends since 2000 in the supply of physicians, NPs, and PAs, and forecasted changes in the supply of each profession through 2030.[46]

Results show healthy numbers of NPs entering the workforce, with minimal growth in the physician population. The study found that between 2010 and 2016, the rate of growth for NPs accelerated to 9.4 percent annually, while growth in the number of PAs slowed to 2.5 percent. During this same period, annual growth in the number of physicians dropped to 1.1 percent. Since 2001, the combined number of NPs and PAs per 100 physicians nearly doubled, increasing from 15.3 to 28.2.[47]

Results also showed that states with restricted NP scope-of-practice had 40 percent fewer NPs compared to those without.

As for the future, regarding the physician shortage that concerns workforce analysts, we found that, between 2016 and 2030, the number of physicians is expected to grow slightly more than 1 percent annually due to the aging and retirement of the physician workforce and the lack of younger physicians to replace them. However, the number of NPs and PAs is projected to grow 6.8 percent and 4.3 percent, respectively, due largely to the number of young people entering these professions. As a result, the workforce will add an estimated combined 477,000 physicians, NPs, and PAs. NPs will contribute nearly 50 percent of this total growth. The combined number of NPs and PAs per 100 physicians will double to about 56.4 by 2030.[48]

In a different study, we focused on the location of the physician workforce, examining a different factor: whether a physician has a highly educated spouse and whether such physicians were less likely to work in rural and underserved areas.[49] Guiding the study was the hypothesis that highly educated dual-career households would more easily accommodate both spouses in large metropolitan areas.

Analyzing data going back to 1960, the study found that physicians were increasingly likely to be married to highly educated spouses—those with an M.D., Ph.D., or graduate degree. The proportion of married physicians whose spouse was highly educated increased steadily from 9 percent in 1960 to 54 percent in 2010. In every year over this period, approximately one-third of physicians' spouses who held graduate degrees were themselves physicians. The increased likelihood of having a spouse with a graduate degree occurred partly because women were a growing proportion of married physicians (from 4 percent in 1960 to 31 percent in 2010) and because female physicians were far more likely than male physicians to be married to a spouse with a graduate degree (68 percent of women versus 48 percent of men in 2010).

Study results showed that physicians married to a highly educated spouse were significantly less likely to live and practice in rural shortage areas. Further, the study found that younger physicians were more likely to be married to a highly educated spouse than physicians born before the 1980s.[50] Taken together, these findings point to an increasingly strong demographic headwind facing rural health workforce policy. Overcoming the challenges in enticing physicians to move to rural and medically underserved areas will be an increasingly steep uphill climb.

The final physician forecasting study that the economics team conducted examined trends in the number of physicians who practice in rural versus non-rural areas.[51] Results showed that the number of physicians per capita in rural areas declined 15 percent between 2000 and 2016 compared to 8 percent growth in non-rural areas.

This is due largely to the aging of physicians working in rural areas and the scarcity of new, younger physicians in rural areas. The number of physicians under 50 practicing in rural areas declined from 9.4 physicians per 10,000 residents to 5.6 physicians per 10,000 people, a decrease of over 40 percent. As a consequence, the number of physicians practicing in rural areas decreased from 14 per 10,000 people in 2000 to 12 per 10,000 people in 2016.

Looking ahead, we forecast that the number of physicians practicing in rural areas will continue decreasing to 9.0 physicians per 10,000 people in 2030, a drop of 35 percent from 2000 and 23 percent relative to 2016 when the rate was 11.7 physicians per 10,000 people. Meanwhile, the number of non-rural physicians is projected to remain steady at just under 31 per 10,000 people, roughly the same proportion observed for 2016.

How Do State-Level Restrictions Affect Access to and Quality of Care?

Health care economist Paul Feldstein describes at least five types of legislative or regulatory strategies a health care professional association may pursue to further its members' self-interest. These strategies include (1) securing policies that increase demand for services provided by its members, (2) maximizing reimbursement or payment for services provided by its members, (3) decreasing the price or increasing the quantity of complementary health professionals, (4) decreasing the availability or increasing the price of substitute providers, and (5) restricting the supply of professions that may compete with its members. These policies are often justified on the grounds of protecting the public from low-quality health care.[52]

Regarding NPs, this framework suggests that some primary care physicians would conceivably support state regulations that limit the supply of NPs, restrict the types of services NPs provide to decrease possible competition with physicians, and require that physicians supervise NPs, so that NPs practice as an economic complement rather than as a substitute. A new study on physician political spending and state-level occupational licensing supports these hypotheses. Results showed that increased spending by physician interest groups increased the probability that a state maintains licensing laws that restrict NPs' practice.[53]

This conceptual framework led us to investigate two means by which a state's NP scope-of-practice laws could influence the quality of care that PCNPs provide. First, the study assessed whether the quality of primary care provided by PCNPs was better in states that either reduced or restricted NP practice than in states with no such restrictions. Higher-quality care in reduced and restricted states would suggest that restrictions do protect quality of care—a position that some physician groups advocate. Drawing on the above studies—which found that beneficiaries receiving care from NPs had lower rates

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of preventable hospitalization, hospital readmissions, emergency department visits, and low-value care—this study also investigated whether beneficiaries living in restrictive states would have less access to NP-provided primary care and more preventable hospital admissions, readmissions, emergency department use, and low-value care than those living in nonrestrictive states.[54]

We used the AANP's system to divide states into the three aforementioned categories: full practice for NPs, reduced practice, and restricted practice. The AANP classification system is useful for several reasons. It is well established, is updated annually or more often, uses generally consistent definitions of a regulation's level of restrictiveness over time, started in the same year (2013) as the Medicare claims data used in the study, and captures the full range of activities and supervision requirements states have regulated.

Overall, using the AANP classification system, results provided no evidence that state-level scope-of-practice restrictions were related in any consistent or discernable way to the quality of care that PCNPs provide. There was no difference in the quality of care that Medicare beneficiaries received between states that reduced or restricted NP scope-of-practice and states that did not restrict NP scope-of-practice. To ensure the robustness of this result, a sensitivity analysis using each of five different scope-of-practice classification systems reported in the literature also found no consistent or discernable pattern.

Finally, study results showed greater use of outpatient services for beneficiaries cared for by both PCNPs and PCMDs in full practice states, as well as lower rates of hospitalization, readmission, and emergency department use.[55] These findings provide further evidence that beneficiaries living in full scope-of-practice states have greater access to care.

The Future of Primary Care Providers: Attitudes, Knowledge, and Behavior

Understanding the future of PCMDs and NPs relies on projections for their fields: What kind of people are, and will grow to be, PCMDs and NPs? Where, how much, and for what pay do they work?

Our national survey of PCNPs and PCMDs (the first national survey of both types of clinicians) provides information to help address these questions.[56] The survey (61.2 percent response rate) gathered information on the practice characteristics of PCNPs and PCMDs. It also collected data on the attitudes, knowledge, and behavior of both types of clinicians toward shortages in the primary care workforce, the impact of expanding the number of PCNPs, NP scope-of-practice, quality of care, responsibility for providing specific services and procedures, job satisfaction, willingness to recommend a career in health care, and other issues. Key characteristics of sampled PCNPs and PCMDs include:

- On average, PCNPs are older but have five fewer years of experience than PCMDs.
- PCNPs work in a greater variety of health care delivery settings (community clinics, schools and universities, offices, parishes, prisons, etc.) than do PCMDs.
- The majority of PCNPs (81 percent) reported working with PCMDs, while 13 percent work independently of physicians. Additionally, 41 percent of PCMDs said they work with PCNPs.
- On average, PCNPs work fewer hours per week than PCMDs (37 hours versus 46 hours) and see fewer patients per week (67 patient visits versus 89 patient visits).
- PCNPs, alone and working with PCMDs, are more likely to treat vulnerable populations, including those on Medicaid, and to accept new Medicaid patients.
- Both types of primary care clinicians spend their time in nearly identical ways and provide similar services, but 56 percent of PCNPs received a fixed salary versus 24 percent of PCMDs. Only 14 percent of PCNPs had their salary adjusted for productivity or quality performance, whereas 50 percent of PCMDs received such salary adjustments.
- PCNPs reported that government and local regulations impede their ability to admit patients to hospitals, make hospital rounds on patients, and write treatment orders in hospitals and long-term care facilities.

In several areas, survey results indicated that physicians' attitudes as individuals do not match their behaviors as a group. Regarding NP scope-of-practice, most PCMDs (77 percent) agree that PCNPs should practice to the full extent of their education and training. However, they do not agree that a primary care practice led by an NP should be eligible to be certified as a medical home, that NPs should be legally allowed to have hospital-admitting privileges, or that they should be paid the same as physicians for providing the same services.

Asked whether expanding the supply of NPs would affect quality of care (measured by the Institute of Medicine's six aims for improving quality of health care and Triple Aim goals), large majorities of PCNPs reported that all dimensions of quality would be better. PCMDs' responses were more diverse and less enthusiastic, with about one-third saying that expanding the supply of NPs would make the safety and effectiveness of care worse. Surprisingly, when asked, "Given what you know about the state of health care, would you advise a qualified high school or college student to pursue a career as a PCNP or PCMD?" PCMDs were more likely to recommend being a PCNP than they would a PCMD (65 versus 51 percent), possibly reflecting physician burnout and dissatisfaction. But perhaps the survey finding that tells the story best is this: When asked how increasing the number of NPs would affect physician employment, 57 percent of PCMDs said their income would decrease, and three-quarters agreed they could be replaced by PCNPs.

Why Removing Restrictions on NPs Helps Remedy the Primary Care Shortage

From this overview of the research program conducted on the primary care NP and physician workforces, supported by the studies listed in Appendix A, several conclusions and observations are apparent.

First, it is unrealistic to rely on or expect the physician workforce alone to provide the primary care Americans need. Significant time, effort, and resources have been spent over many decades on various public and private policies to increase the supply and geographic reach of primary care physicians, yet today there is a growing national shortage of such physicians and continued uneven geographic distribution of primary care. These realities mean tens of millions of Americans lack adequate access to beneficial primary care services, often enduring significant delays before obtaining care. Hit particularly hard are people in rural and underserved areas, who are generally older, less educated, poorer, and sicker—the very populations who need primary care the most.

As large numbers of primary care physicians retire over the next decade and demand increases for primary care, current shortages of primary care are projected to worsen, and fewer physicians will be practicing in rural areas. The even-larger projected shortage of specialist physicians will only make matters worse, as many specialists provide considerable amounts of primary care. And, as the proportion of physicians who are married to highly educated spouses increases, the already formidable challenges of attracting physicians to rural and Health Professional Shortage Areas will become even more daunting.

In contrast, studies of the PCNP and PCMD workforces find that the number of PCNPs has been growing much more quickly than the physician workforce. The number of PCNPs will increase dramatically, while the number of PCMDs will grow little through 2030. And PCNPs are more likely to practice in rural areas, where the need is greatest.

When assessing state-level restrictions on NPs, our study showed that populations in states with reduced or restricted practice of NPs had significantly less geographic access to PCNPs. This finding has also been reported by others, indicating the role state regulations have in influencing access to primary care (Appendix A).[57] Clearly, state-level restrictions impede access to and quality of primary care. This alone should be cause for concern among policymakers seeking to improve public health.

Using different data and methods, the studies described in this report consistently show that PCNPs are significantly more likely than PCMDs to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualified for Medicare as a disability, and dual-eligibles are all more likely to receive primary care from PCNPs than from PCMDs. PCNPs working independently of PCMDs and those working with them are more likely to accept Medicaid recipients, take care of those without insurance, and accept lower payments than are PCMDs who do not work with PCNPs.

Another major finding of this body of research is that, after controlling for differences in patient severity and sociodemographic factors, the cost of care provided to Medicare beneficiaries by PCNPs was significantly lower than primary care provided by PCMDs. Even after accounting for the lower payment PCNPs receive relative to PCMDs, the cost of PCNP-provided care was still significantly lower. Taken together, these findings paint a favorable picture of PCNPs' contributions.

However, the viability of increased reliance on PCNPs still depends on the simple question at the core of this project: Can PCNPs provide health care of comparable quality to that provided by PCMDs? Our studies showed that beneficiaries who received their primary care from PCNPs consistently received significantly higher-quality care than PCMDs' patients with respect to decreasing hospital admissions, readmissions, emergency department use, and ordering of low-value care (specifically, MRI images for low back pain). While beneficiaries treated by PCMDs received slightly more services involved in managing chronic diseases than those receiving primary care from PCNPs, the differences were marginal.

State-level NP scope-of-practice restrictions do not help protect the public from subpar health care.

These results held when vulnerable populations of Medicare beneficiaries were analyzed separately and compared to those cared for by PCMDs. In fact, the differences in quality of chronic disease management between PCMDs and PCNPs narrowed considerably, and some disappeared altogether. These results align with the findings of many other studies conducted over the past four decades.

Furthermore, state-level NP scope-of-practice restrictions do not help protect the public from subpar health care. Analysis of different classifications of state-level scope-of-practice restrictions provided no evidence that Medicare beneficiaries living in states that imposed restrictions received better quality of care.[58] Some physicians and certain professional medical associations have justified their support for state regulations to limit NP scope-of-practice on the grounds that they are necessary to protect the public from low-quality providers and to assert that physicians must be the leaders of the health care team. We found no evidence to support their claim, as others have also recently reported.[59] Further, our analysis showed that Medicare beneficiaries living in states with reduced or restricted NP scope-of-practice used more resources (hospitalizations, readmissions, and emergency department admissions sensitive to primary care) than did beneficiaries living in states without such restrictions, indicating that these beneficiaries had less access to the positive contributions of PCNPs.

Despite this body of evidence, our national survey of primary care clinicians revealed that around one-third of PCMDs believe increasing the number of PCNPs would impair the safety and effectiveness of care. This could indicate that physicians are not aware of the findings of research. Alternatively, it should be called what it is: an excuse for a barrier to entry, meant to protect some physicians' narrow interests. And it comes at the expense

of effective primary care for many Americans who need it.

The evidence leads to three recommendations that can help overcome the growing challenges facing the delivery of primary care in the US. Each recommendation is geared toward a different group: public policymakers, private policymakers, and PCMDs and PCNPs themselves.

1. Private policymakers—including hospital boards of directors, established and emerging integrated health care–delivery systems (e.g., large hospital-based systems and accountable care organizations), private commercial and not-forprofit insurers, health care and hospital associations, health education associations, and health care foundations—should develop forums to bring PCNPs, PCMDs, and their respective state and local associations together to engage in meaningful dialogue. Hospital boards and credentialing bodies should allow NPs to practice to the fullest extent of their training and ability. The evidence suggests this will be a great service to people lacking access to care and to the solvency of Medicare. Doctors (as individuals) overwhelmingly favor allowing NPs to practice to the full extent of their education and training. This can become a reality on a hospital-to-hospital, health-system-to-health-system basis.
2. Physicians must understand that NPs, too, are providing health care to those in need. NPs and physicians should work together to better understand each other. It may behoove individual physicians and nurses to discuss how, together, disagreements can be better managed, even resolved. This could be a first step toward building a relationship that allows for roles and practices to evolve—that respects each other's strengths and ultimately leads to a workforce that is more responsive to communities' health needs, particularly in rural and underserved areas and among vulnerable populations.
3. Public policymakers: Drop the restrictions on PCNP scope-of-practice! These are regressive policies aimed at ensuring that doctors are not usurped by NPs, which is not a particularly worthwhile public policy concern, especially if it comes at the expense of public health. The evidence presented here suggests that scope-of-practice restrictions do not help keep patients safe. They actually decrease quality of care overall and leave many vulnerable Americans without access to primary care. It is high time these restrictions are seen for what they are: a capitulation to the interests of physicians' associations.

Conclusion

The evidence discussed in this report points to a commonsense solution to primary care workforce-supply problems. The NP workforce is growing, far outpacing the growth of the primary care physician labor force. NPs are more likely to work in rural areas, which already do and will increasingly need more primary care providers. They are more likely to serve poor and vulnerable Americans, and their services cost less. Most importantly, they provide primary care of equal or better quality compared to physicians.

For all those reasons, scope-of-practice restrictions should be lifted in states across the country, and health care administrators should allow NPs to take on expanded roles in primary care settings. For the health of Medicare and millions of people, NPs must be allowed to provide primary care to more Americans.

About the Author

Peter Buerhaus is a health care economist and professor of nursing at Montana State University and a member of the American Academy of Nursing and the National Academy of Medicine.

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Appendix A

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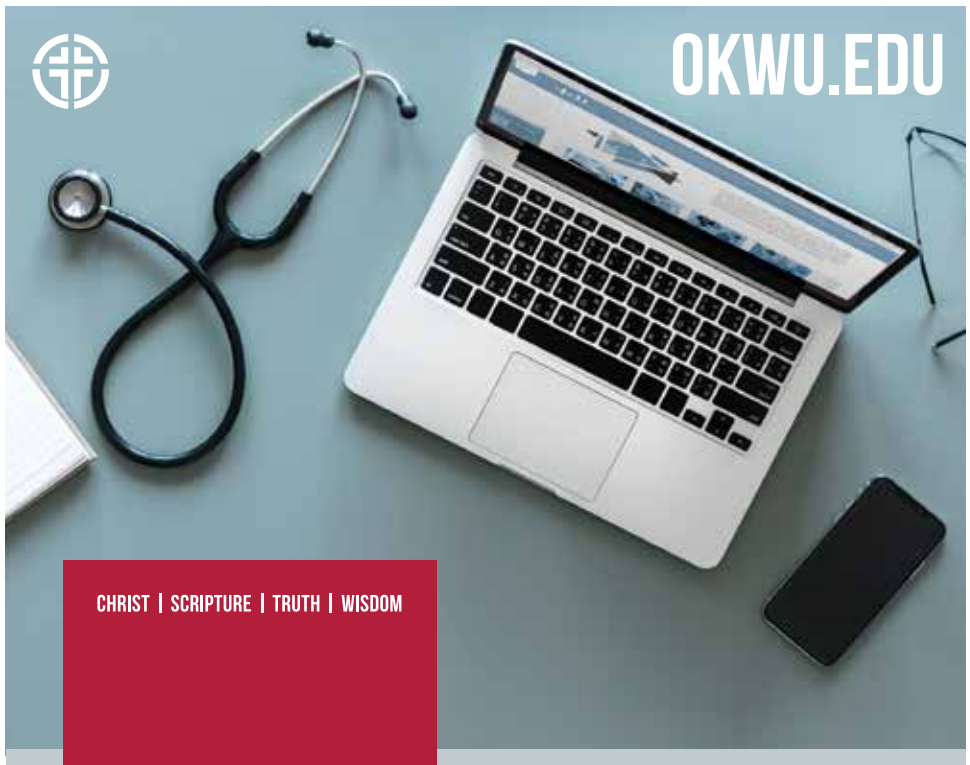

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